Welcome to Your King County Benefits for Regular Employees

Your King County Benefits **is the first place to turn when you want to know more about your county benefits or if you just have a benefit question.**

About This Guide

As a King County employee, you receive a comprehensive benefit package for you and your eligible dependents.

How to Use This Guide

Your King County Benefits has a number of features that will help you find information easily. Each benefit section tells you who is eligible for coverage, what coverage is available and when coverage is effective. You'll find a glossary at the end of some of the sections.

The guide is intended to help you use your benefits most effectively for your particular situation, which means it sometimes describes things that could limit your benefits.

Although the benefit descriptions in this guide contain certain key features and brief summaries of the county's benefit plans, they're not detailed descriptions. If you have questions about specific plan details, contact the plan's third-party administrator or Benefits, Payroll and Retirement Operations.

We've made every attempt to ensure the accuracy of the information in this guide. However, if there's any discrepancy between the benefit descriptions in this guide and the insurance contracts, the insurance contracts will always govern. In addition, no person has the authority to make any oral or written statements of any kind that would conflict with the insurance contracts or would alter the insurance contracts maintained in conjunction with the plans.

The county intends to continue its benefit plans indefinitely, but reserves the right to amend or terminate them at any time, in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents.

About the Benefit Plans

King County has sole discretionary authority to determine who is eligible to enroll in any of the benefit plans, and to resolve appeals based on eligibility.

In its role as plan fiduciary, the county has designated Regence as the medical claims fiduciary and Express Scripts as the Pharmacy Benefit Manager for KingCare℠, and Group Health as claims fiduciary for SmartCare Connect. Regence, Express Scripts and Group Health have discretionary authority to apply the terms of their respective plans for the purpose of paying claims and resolving claims appeals under the plan.

For benefits provided by the health maintenance organization and under the dental, vision, life, accidental death and dismemberment (AD&D) and long-term disability (LTD) insurance contracts, the county administers eligibility as outlined in the insurance contracts. Group Health, Aetna Life Insurance and CIGNA Group Insurance have the sole discretionary authority to apply the terms of their respective plans for the purpose of determining eligibility for claims payment and resolving claims appeals under the plans.

The plans listed in this guide are considered to be "Grandfathered" according to the guidelines provided in the Patient Protection and Affordable Care Act (PPACA).

About Your Employment

The information in this guide does not create a contract of employment between the county and any employee.

If You Have Questions

If you would like to review any of the insurance contracts, you may contact Benefits, Payroll and Retirement Operations.

Health Care Overview

King County provides you with medical (including prescription drug), dental and vision coverage that offers flexibility and choice. You can choose the health care plan that's right for you and your eligible dependents.

Participating in the Health Care Plans

To effectively use your health care benefits, you need to know how they work. This section explains who is eligible to participate in the King County health care benefits, how and when to enroll, when coverage begins and ends, and how certain life event changes affect your eligibility to participate in the health care plans.

HEALTH CARE PARTICIPATION INFORMATION ONLY

The information about eligibility and changing coverage in this section applies to the county's health care benefits only—medical, dental and vision coverage.

For eligibility and participation information regarding other benefits, see the separate descriptions of each benefit in this guide.

Who Is Eligible

You and your eligible dependents are eligible for the county's health care plans.

Employee

You're eligible for county-paid medical, dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and children) you enroll if you're:

- a regular part-time or full-time employee;
- a full-time Local 587 employee;
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible); or
- an employee eligible for benefits through the provisions of the Affordable Care Act (ACA).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

You're not eligible for these benefits if:

- you work less than half-time in a calendar year;
- you're a temporary or seasonal employee; or
- you work in a capacity that, at the discretion of human resources, is considered contract work or independent contracting.

Spouse/Domestic Partner

IMPORTANT!

No double coverage — If you and your spouse/domestic partner are both county employees, you may not cover yourselves and each other as a dependent under your medical, dental or vision plans.

Your spouse/domestic partner is eligible for county-paid medical, dental and vision coverage.

However, when a spouse/domestic partner is in active full-time military service, he/she isn't eligible for medical, dental and vision coverage.

When you enroll your spouse/domestic partner, you must complete the online Marriage/Domestic Partnership form, which contains an Affidavit of Marriage/Domestic Partnership. If you want, you may also submit a copy of your marriage certificate.

If your spouse/domestic partner has access to other medical coverage, you must pay a benefit access fee of $75 a month through payroll deduction for him/her to be covered under your county-paid medical plan.

Domestic Partners

While the county pays for your domestic partner's medical, dental and vision coverage, the IRS taxes you on the value of that coverage. This value is added to the gross pay shown on your paycheck (and on your W-2 at year-end); federal income and Social Security (FICA) taxes are withheld on the higher amount; and then the value is subtracted from your gross pay.

Children

Children are eligible for county-paid medical, dental and vision coverage.

However, when a child is in active full-time military service, he/she isn't eligible for medical, dental and vision coverage.

Eligible children include:

- your children or your spouse/domestic partner's children:
  - your children are eligible for medical, dental and vision coverage up to age 26. Your adult children may be covered even if they are not dependent on you for support and even if they are married, though you may not cover their spouses or their children;

  "Children" or "child" means:

  - biological children;
  - adopted children, or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption;
  - stepchildren; and
  - legally designated wards, who include legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan.
- a child (as defined above) age 26 or older if the child:
  - was incapacitated and continuously covered under your plans before and after age 26;
  - continues to be incapacitated due to a developmental or physical disability;
  - is incapable of self-sustaining employment; and

- is dependent on you for more than 50% support and maintenance.

For dental and vision only: If you don't notify Benefits, Payroll and Retirement Operations that you want to continue your child's dental and vision coverage before your child turns 26, dental and vision coverage for your child is automatically discontinued, and you will only be able to reinstate it during open enrollment or within 30 days after a qualifying life event.

SPECIAL ENROLLMENT RIGHTS UNDER THE 2009 CHILDREN'S HEALTH INSURANCE PROGRAM

The Children's Health Insurance Program allows you and your eligible dependents to enroll in a group health plan when:

- You or your dependent loses Medicaid coverage or coverage under the Children's Health Insurance Program because you are no longer eligible, or
- You or your dependent qualifies for state assistance in paying your employer group medical plan premiums (in the State of Washington, this provision provides premium assistance to children whose family household income is less than 200% of the federal poverty level).

If you qualify for special enrollment rights under the Children's Health Insurance Program and want to enroll in a King County medical plan, you must notify Benefits, Payroll and Retirement Operations within 60 days following the event. For all other special enrollment events, notification must occur within 30 days following the event. Otherwise, you must wait until the next open enrollment period to enroll in coverage.

Domestic Partner's Children

While the county pays for the medical, dental and vision coverage of your domestic partner's children, the IRS taxes you on the value of the coverage. As with your domestic partner's coverage, this value is added to the gross pay shown on your paycheck (and on your W-2 at year-end); federal income and Social Security (FICA) taxes are withheld on the higher amount; and then the value is subtracted from your gross pay.

Disabled Dependent Children

If you want to continue coverage for a disabled child when he/she turns 26, you must submit a Continue Coverage for Disabled Adult Child form, along with a certification of disability and incapability of self-sustaining employment, to Benefits, Payroll and Retirement Operations within 30 days of the child's 26th birthday. You also must provide certification of the child's continued disability and incapability of self-sustaining employment annually thereafter.

If your dependent child becomes disabled before age 26 while covered under your county benefits, you can follow the same process described above to avoid paying premiums.

Qualified Medical Child Support Order (QMCSO)

In accordance with applicable law, the county provides medical, dental and vision coverage for certain children of yours, called "alternate recipients," if directed by certain court or administrative orders. These orders include a decree, judgment or order from a state court (including approval of a settlement agreement) or an administrative order that requires these plans to include a child on your coverage and make any applicable payroll deductions.

A QMCSO is generally considered qualified and enforceable if it specifies:

- the employee's name and last known address;
- each alternate recipient's name and address;
- coverage the alternate recipient will receive;

- the coverage effective date;
- how long the child is entitled to coverage; and
- each health plan subject to the order.

Benefits, Payroll and Retirement Operations will promptly notify you and the alternate recipient when a QMCSO is received and explain what procedures will be used to determine if the order is qualified. Once the determination is made, Benefits, Payroll and Retirement Operations will notify you and the alternate recipient by mail.

How and When to Enroll

You may enroll in the King County health care plans:

- when you're first eligible;
- during the annual open enrollment; or
- after a qualifying life event.

Enrolling When First Eligible

You receive benefit enrollment forms in your Regular Employee New Hire Guide as well as wellness assessments for you and your spouse/domestic partner when you attend a new employee orientation after you first report to work.

If your spouse/domestic partner has access to other medical coverage, you pay a benefit access fee of $75 a month through payroll deduction for him/her to be covered under your county-paid medical plan.

When you first become eligible for benefits, you and your spouse/domestic partner are given the opportunity to take a confidential wellness assessment, which asks questions about lifestyle and behavior to assess your risk level for developing a chronic health condition. Your decision to take or not to take the wellness assessment determines the out-of-pocket expense level for your medical benefits.

Your coverage begins the first day of the month following your hire date (that is, the first day you report to work). However, if your hire date is the first day of the month, your coverage begins the same day.

Enrolling in the Health Care Plans

To enroll in your health care plans, you must return the benefit enrollment forms in your Regular Employee New Hire Guide to Benefits, Payroll and Retirement Operations **within 30 days of your hire date**, which is the first day you report to work. If you don't meet this deadline:

- you'll be assigned KingCare℠ as your default medical coverage at the out-of-pocket expense level you achieve by taking or not taking the wellness assessment within 14 days of the new employee orientation;

- you won't be able to enroll your eligible dependents for any health care coverage—medical, dental or vision—until you have a qualifying life event or enroll them during the next annual open enrollment; and
- you won't be able to change your medical plan until the next annual open enrollment, unless you experience a qualifying life event that would allow such change.

Taking the Wellness Assessment

In addition to returning your benefit enrollment forms, you and your spouse/domestic partner must each decide whether to take the wellness assessment. You and your spouse/domestic partner have **14 days from the day you attend your new employee orientation** to lower your out-of-pocket expenses by taking the wellness assessment and returning it to Benefits, Payroll and Retirement Operations.

Participation is voluntary. If you and your spouse/domestic partner complete and return the wellness assessment within 14 days, you'll receive the **Gold** (lowest) out-of-pocket expense level for your medical benefits. If you and your spouse/domestic partner choose not to participate or don't complete and return the wellness assessment within 14 days, you'll receive the **Bronze** (highest) out-of-pocket expense level for your medical benefits.

Your spouse/domestic partner doesn't need to take the wellness assessment if you don't intend to cover him/her under the county's medical coverage.

HEALTHY INCENTIVES℠ IN BRIEF

Healthy Incentives℠ is a wellness program that encourages employees and their spouse/domestic partners to take ownership of their health by participating in a wellness assessment and individual action plan.

The wellness assessment asks questions about lifestyle and behavior to assess your risk level for potentially developing a chronic health condition. The individual action plan supports you in maintaining and/or improving your health based on the confidential information from your wellness assessment.

Your participation in the wellness assessment and individual action plan determines the out-of-pocket expense level for your medical benefits.

Opting Out of Medical Coverage

You may opt out of medical coverage may opt out at any time during the year if you become covered by another medical plan during the year.

As a newly benefit-eligible employee, you have a unique opportunity that your eligible dependents do not—you may opt out of medical coverage and receive an additional $65 in monthly pay, which is taxed as ordinary income. To opt out of medical coverage, you must have coverage through another employer's medical plan (or a county plan if you're covered by a spouse/domestic partner who is a county employee) and submit a copy of the other medical plan ID card or other verification of coverage with your enrollment form.

If you opt out of medical coverage and lose your other medical coverage during the year, you may opt back in before the next annual open enrollment. You must complete the online Employee Lost Medical Coverage form within 30 days of losing that coverage. Your coverage will take effect on the first of the month after your other coverage ends.

If you don't opt back in within 30 days, you'll have to wait until the next annual open enrollment to receive coverage, which will take effect January 1 of the following year.

Enrolling During the Annual Open Enrollment

During the annual online open enrollment, you may:

- change medical plans;
- add eligible dependents; and
- discontinue dependent coverage.

Coverage takes effect January 1 of the following year.

If you don't go online to make elections during the annual open enrollment, you and your covered dependents will remain in your current medical plan and automatically receive dental and vision coverage for the following year.

However, you must go online to make elections during the annual open enrollment if you want to:

- opt out of medical coverage;
- opt out of the benefit access fee;
- add or discontinue dependent coverage; or
- participate in a flexible spending account (FSA) in the following year; you must elect or re-elect FSAs each year.

If You're on a Paid Leave of Absence

If you're on a paid leave of absence or on a leave of absence under the Family Medical Leave Act (FMLA) or King County Family Medical Leave (KCFML) during the annual open enrollment, you'll need to go online to:

- elect a benefit access fee option (You continue to pay the benefit access fee if you cover a spouse/domestic partner while on a paid leave of absence;
- enroll or re-enroll in a flexible spending account; and
- make any other changes to your benefits.

When and How to Make Changes

For Benefits Other Than Health Care

When making changes, you may want to update other information that may affect your benefits—for example, if you and your spouse divorce, you may want to update your beneficiary information with Aetna Life Insurance for life insurance and with CIGNA Group Insurance for accidental death and dismemberment (AD&D) insurance and long-term disability (LTD) insurance.

Qualifying Life Events

"Qualifying life events" allow you to make midyear changes to your health care coverage that you normally wouldn't be allowed to make outside of the normal open enrollment period.

If you experience a qualifying life event, it may impact your benefit coverage, taxes, and beneficiaries, and require you to add, remove or change benefits. Examples of qualifying life events include:

- getting married or establishing a domestic partnership;
- divorce or ending a domestic partnership;
- becoming a parent;
- taking a leave of absence;
- becoming disabled;
- retiring;
- leaving King County employment;
- a death in the family; or
- a change in coverage under another employer plan.

HOW TO MAKE CHANGES TO YOUR BENEFITS

To make changes to your benefit coverage due to a qualifying life event, access the appropriate form online at the Benefits, Payroll and Retirement Web site.

Changing Your Medical Plan

Special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) allow you and your eligible dependents to change to another county medical plan at the time of a qualifying life event, provided you're receiving medical coverage as an:

- active employee;
- employee on leave without pay under COBRA (Consolidated Omnibus Budget Reconciliation Act); or
- employee on medical leave under the Family Medical and Leave Act (FMLA) or King County Family Medical Leave (KCFML).

If you have a qualifying life event, you and your eligible dependents may either:

- keep your existing medical plan; or
- enroll in another medical plan for which you and your dependents are eligible.

To enroll in another medical plan, you must make the change online within 30 days of the qualifying life event.

Adding Eligible Dependents

If you add a spouse or domestic partner, you must complete the online Marriage/Domestic Partnership form, which contains an Affidavit of Marriage/Domestic Partnership. If you want, you may also submit a copy of your marriage certificate.

When completing the Marriage/Domestic Partnership form, you'll need to elect the benefit access fee option that applies to your situation. If you don't make an election, you'll automatically be charged the $75/month benefit access fee through payroll deduction to cover a spouse/domestic partner when he/she has access to other medical coverage. You may later ask that the benefit access fee deduction be discontinued, but any fees already deducted will not be refunded.

Except for birth or placement for adoption, you must complete the Add/Change Dependent form online within 30 days of a qualifying life event to add an eligible dependent for health care coverage, which includes medical, dental and vision coverage.

When you add an eligible dependent within 30 days, your dependent's coverage begins on the first of the month after the qualifying life event occurred (for births or adoptions, coverage is retroactive to the child's birth or adoption placement date). If you don't complete the online form within 30 days, you must wait until the next annual open enrollment to add the eligible dependent for coverage.

At this time, you may enroll in a new flexible spending account (FSA) or adjust the amount of an existing FSA online.

Birth or Placement for Adoption

A newborn is automatically covered under the mother's health care plan for the first three weeks. You have 60 days to enroll a newborn or a newly adopted child for health care (medical, dental and vision) coverage. Coverage will be retroactive to the child's birth or adoption placement date. However, because you have only 30 days to make changes to supplemental life and accidental death and dismemberment (AD&D) coverage, it's highly recommended that you complete the Birth/Adoption form online within 30 days of birth or placement for adoption to take advantage of your life/AD&D change options.

Qualified Medical Child Support Order (QMCSO)

When Benefits, Payroll and Retirement Operations receives a QMCSO, the child is automatically added for coverage according to the terms of the document—you don't need to complete the Add/Change Dependent form online.

Opting Back Into Health Coverage After Opting Out

If you previously opted out of medical coverage and lose coverage elsewhere, you must complete the online Employee Lost Medical Coverage form within 30 days of losing coverage if you want to opt back into the county's health care plans. If you don't complete the form within 30 days, you may not opt back in until the next annual open enrollment.

If you opted out when you first became eligible for county benefits because you had COBRA coverage, the COBRA coverage must be exhausted before you can opt back into county coverage midyear; you can also opt in during the annual open enrollment.

For other than COBRA coverage, you may opt in if your loss of coverage is due to:

- divorce or dissolution of a domestic partnership;
- a change in job status such as reduction of hours;

- termination of employer contributions toward the other coverage;
- termination of employment; or
- death of a spouse/domestic partner.

Requesting Coverage for Someone under a State Program

If the Washington State Department of Social and Health Services determines that it's more cost-effective for a person under a state medical assistance program or a children's health insurance program to enroll in an employer-sponsored health care plan, you may add that person to your county health care plan at any time during the year as long as he/she meets the county's eligibility requirements. To do so, contact Benefits, Payroll and Retirement Operations.

Changes You May Make at Any Time

There is one change you may make to your health care coverage at any time.

Discontinuing Dependent Coverage

You may discontinue health care coverage for eligible dependents at any time in accordance with plan documents.

However, discontinuing coverage for a spouse/domestic partner doesn't change your level of out-of-pocket expenses under your medical coverage in the year you discontinue coverage for your spouse/domestic partner. If you've earned the lowest out-of-pocket expense level and your spouse/domestic partner has earned the highest out-of-pocket expense level for a given year, for example, your family coverage is at the highest out-of-pocket expense level. Your family coverage remains at the highest out-of-pocket expense level for the remainder of that year even though you've discontinued coverage for your spouse/domestic partner.

When you voluntarily discontinue dependent coverage, you may not re-enroll your eligible dependents until the next annual open enrollment or after a qualifying life event occurs.

When Coverage Begins

ID CARDS

When you enroll in medical coverage, which includes prescription drug coverage, you receive an ID card or cards that identify you as a plan member. Carry your card with you because physicians, hospitals and pharmacies will ask to see it when you receive care.

If you need care before you receive your card, or if you lose your card, call your plan for information about your coverage before you receive treatment to be sure the plan you're in covers the treatment you're about to receive.

You do not receive ID cards for your dental and vision coverage. For more information on using your dental and vision benefits, see "Using the Dental Plan" in "Dental Plan" and "Using the Vision Plan" in "Vision Plan."

Coverage begins on the first day of the month following your hire date, which is the first day you report to work, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

If you're hospitalized under another benefit plan and you're in the hospital the day county coverage would normally begin, the other plan usually continues to provide your coverage until you're discharged.

When you change coverage during the annual open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

When you return from an unpaid leave of absence, your coverage resumes on the first day of the month following your return. If you return on the first day of the month, your coverage resumes the same day.

Eligible Dependents

Coverage for the eligible dependents you enroll in your county health care plan begins when your coverage begins, with the exceptions listed below. If you don't enroll eligible dependents when you enroll, you must wait until the next annual open enrollment or a qualifying life event to add them to coverage.

For eligible dependents added because of a qualifying life event:

- health care coverage for your new spouse/domestic partner begins on the first day of the month following the date you marry or establish your domestic partnership. If you marry or establish your domestic partnership on the first day of the month, coverage begins the same day;
- health care coverage for your newborn or newly adopted child is retroactive to the date of birth or placement; and
- health care coverage for a child who isn't a newborn or adopted begins the first day of the month following the event that qualified him/her to be added. If the event occurs on the first day of the month, coverage begins the same day.

Coverage for newborns is provided under the mother's health care plan for the first three weeks of life. To continue the newborn's coverage after that, the newborn must be eligible and enrolled within 60 days of his/her birth.

When You Have Other Coverage

If you or an eligible dependent has coverage under the King County health care plans and coverage under another health care plan or Medicare, the county's benefits are coordinated with those provided by the other plan so that your combined coverage doesn't exceed the provider's fees for eligible expenses.

Coordinating with Other Health Plans

The county's KingCare[SM] plan, dental plan and vision plan coordinate benefits under a non-duplication coordination of benefits policy between the primary and secondary plans. That means when a plan is primary, it pays benefits first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it had been primary.

The county's Group Health plan coordinates benefits under a standard coordination of benefits (COB) policy between primary and secondary plans. That means if Group Health is primary, it pays first; if it is secondary, it pays up to an amount equal to the difference between the total charge and what the primary plan paid (the exact amount depends on the calculation of COB savings to Group Health). If your children have double coverage through the county's Group Health plan because both you and your spouse work at the county and each of you has employee and dependent coverage, then your children's copays are waived.

The following applies to KingCare℠, Group Health, the dental plan and the vision plan:

If you're a county employee whose spouse/domestic partner has coverage through another plan and you cover each other under your respective plans, then your plan is primary for you and secondary for your spouse/domestic partner, and your spouse/domestic partner's plan is primary for him/her and secondary for you.

However, if you and your spouse/domestic partner are both county employees and insured by a county plan, you may **not** cover each other under your medical and vision plans so that you each are double covered. Instead, one of you may opt out of medical coverage and be covered by the other. If each of you remains covered under your own county plan and neither of you opts out to be covered by the other, each of you may cover your eligible children under your plan.

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine which plan is primary for eligible children covered under both parents' plans:

- the plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents have the same birthday, in which case the plan that has covered one of the parents the longest is primary. If the other plan doesn't have this rule, its provisions apply.
- if the parents are divorced or legally separated, the following rules apply:
  - if a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.
  - if there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody.
  - if the parent with custody has remarried, the plan that covers the child is determined in the following order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a spouse/domestic partner of a retired or laid-off person, the plan of the person actively employed pays first unless the other plan doesn't have a provision regarding retired or laid-off employees.

The plans have the right to obtain and release data as needed to administer these procedures for coordination of benefits.

Coordinating with Medicare

If you keep working for the county after you become eligible for Medicare, you may:

- continue your county medical coverage and integrate the county plan with Medicare (in this case, the county medical plan is primary and Medicare is secondary); or
- discontinue your county medical coverage and enroll in Medicare.

If you discontinue your county medical coverage as an employee and enroll in Medicare, you may not cover your dependents under the county medical plan. However, you may continue your county dental and vision coverage and continue to cover eligible dependents under the county dental and vision plans.

Federal rules govern the coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering an active employee or eligible dependent of an active employee. Medicare is primary in most other circumstances, including for domestic partners.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan directly.

Acts of Third Parties

The subrogation and right of recovery rules apply to KingCare℠, Group Health, the dental plan and the vision plan.

KingCare℠

When you or your covered dependent is injured or becomes ill because of the actions or inactions of a third party, KingCare℠ may cover your eligible medical and prescription drug expenses. However, to receive coverage, you must notify the plan that your illness or injury was caused by a third party, and you must follow special plan rules. This section describes the KingCare℠ procedures with respect to subrogation and right of recovery.

"Subrogation" means that if an injury or illness is someone else's fault, KingCare℠ has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A "right of recovery" means that the plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party who caused the illness or injury.

By accepting plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that KingCare℠:

- has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such illness or injury;
- may appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such illness or injury; and
- may bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the illness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed below—through a judgment, settlement or otherwise—when an illness or injury is the result of a third party, you agree to place the funds in a separate, identifiable account and that KingCare[SM] has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must repay KingCare[SM] first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury. You must repay KingCare[SM] up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must repay KingCare[SM] whether the third party admits liability and whether you've been made whole or fully compensated for your injury. If any money is left over, you may keep it.

In addition, KingCare[SM] isn't required to participate in or contribute to any expenses or fees (including attorneys' fees and costs) you incur in obtaining the funds.

The plan's sources of payment through subrogation or recovery include (but aren't limited to) the following:

- money from a third party that you, your guardian or other representative receives or is entitled to receive;
- any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representative receives;
- any equitable lien on the portion of the total recovery owed to the plan for benefits it paid; and
- any liability or other insurance—for example, uninsured motorist, underinsured motorist, medical, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage—that is paid or payable to you, your guardian or other representative.

As a participant in KingCare[SM], you're required to:

- cooperate with the plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the plan's subrogation or recovery rights outlined in this section;
- notify the plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained illness or injury; and
- provide all information requested by the plan, the claims administrator or their representatives, or the plan administrator or its representatives.

KingCare[SM] may terminate your participation and/or offset your future benefits in the event that you fail to provide the information and authorizations or to otherwise cooperate in a manner that the plan considers necessary to exercise its rights or privileges.

Group Health

When you or your covered dependent is injured or becomes ill because of the actions or inactions of a third party, Group Health may cover your eligible medical and prescription drug expenses. However, to receive coverage, you must notify Group Health that your illness or injury was caused by a third party, and you must follow special plan rules. This section describes Group Health's procedures with respect to subrogation and right of recovery.

Group Health's subrogation and reimbursement rights will be limited to the excess or the amount required to fully compensate the injured party or the loss sustained, including general damages.

"Subrogation" means that if an injury or illness is someone else's fault, Group Health has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A "right of recovery" means that the plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party who caused the illness or injury.

By accepting plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree to:

- cooperate fully with Group Health in its efforts to collect medical expenses it is entitled to recover;
- provide Group Health with information about any third parties related to the injury, including any settlement or other payments related to the injury;
- allow Group Health to associate with the injured party or intervene in any legal or other action related to the injury; and
- allow Group Health to initiate its own direct action for reimbursement, including billing you if you don't take action to recover funds from any third party.

If you fail to cooperate with Group Health or settle a claim without protecting Group Health's interest, you will be held responsible for reimbursing Group Health for all your medical expenses associated with the injury.

To the extent that you recover funds from any third party, you agree to hold the funds in trust or your possession until Group Health's rights are fully determined.

Group Health will not cover the cost of attorneys' fees or collection costs to attorneys representing you unless there is a written fee agreement with Group Health before any collection efforts are made. When reasonable collection costs have been incurred with Group Health's prior written agreement, Group Health agrees to an equitable apportionment of the collection costs between you and Group Health up to a maximum responsibility of one-third of the amount recovered on behalf of Group Health. Group Health will not pay legal fees for services that are not reasonable and necessary, do not benefit Group Health and/or are incurred without a written fee agreement.

If Group Health finds that it must initiate action against you to enforce its rights, you agree to pay Group Health attorneys' fees and costs associated with the action.

Dental Plan

When you or your covered dependent is injured or develops a condition possibly caused by another person, Delta Dental of Washington may cover your eligible dental expenses. However, to receive coverage, you must notify Delta Dental that your injury or condition was caused by a third party, and you must follow special plan rules.

So that Delta Dental can pursue its rights to collect reimbursement from the third party, Delta Dental will not be obligated to pay for your dental expenses or prorate any attorneys' fees incurred in pursuing its rights, unless and until you, or someone legally qualified and authorized to act for you, agrees to:

- include those amounts in any insurance claim or liability claim made against the third party for the injury or condition;
- repay Delta Dental for those amounts included in the claim that exceed your full compensation; and
- cooperate fully with Delta Dental in pursuing its rights, supply Delta Dental with any and all information requested, and execute any and all instruments Delta Dental reasonably needs for that purpose.

Vision Plan

When you or your covered dependent is injured or develops a condition caused by the wrongful act or omission of another person, Vision Service Plan (VSP) may cover your eligible eye care expenses, excluding routine vision care. However, to receive coverage, you must notify VSP that your injury or condition was caused by a third party, and you must follow special plan rules.

As long as you're made whole for all other damages resulting from the wrongful act or omission before VSP is entitled to reimbursement, you will:

- reimburse VSP for the reasonable cost of services paid by VSP, to the extent permitted by law, immediately upon collecting damages, whether by action or law, settlement or otherwise; and
- fully cooperate with VSP in pursuit of its rights, to the extent permitted by law, to be reimbursed by the third party, his/her agent or the court for the reasonable value of services provided by VSP.

Overpayment

The county's health care plans have the right to recover amounts they paid that exceed the amount for which they're liable. These amounts may be recovered from one or more of the following as determined by the plans:

- persons to or for whom the payments were made;
- other insurers;
- service plans; and
- organizations or other plans.

These amounts may be deducted from your future benefits or a covered dependent's benefits, even if the original payment wasn't made on that individual's behalf.

The recovery rights of the plans include benefits paid in error due to any false or misleading statements made by you or your covered dependents, or your failure to discontinue coverage for a dependent who became ineligible.

In paying for services, the plans may, at their option, make the payment to you, the provider or another carrier. The plans also will make payments on behalf of an enrolled child to his/her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. Payments made according to these provisions will discharge the plans to the extent of the amount paid, so that the plans will not be liable to anyone aggrieved by their choice of payee.

When Coverage Ends

Coverage under the health care plans ends under certain circumstances.

EXTENSION OF COVERAGE

If you or your covered dependent is hospitalized when your medical coverage terminates, your coverage under KingCare℠ or Group Health continues until discharge. Coverage ends on the date of discharge or when you or your covered dependent reaches the plan maximum, whichever comes first.

The Group Health extension of coverage also ends when:

- it is no longer medically necessary to be an inpatient;
- you or your covered dependent becomes covered under another group plan that provides benefits for the hospitalization;
- another carrier would provide benefits for the hospitalization if this coverage didn't exist; or
- you or your covered dependent becomes eligible for Medicare.

If you or your eligible dependent is covered under KingCare℠ while totally disabled and coverage ends for any reason other than plan termination, KingCare℠ coverage may be extended for 12 months at no cost to you. The disabled person may choose either this extension of medical coverage or coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). However, electing the extension means forfeiting the right to elect COBRA coverage and convert to an individual policy. Other covered dependents may be able to elect coverage through COBRA.

In the event that you or your covered dependent cease to be eligible for enrollment, or cease to be enrolled, or in the event of termination of this dental plan, DDWA will not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise covered benefits under the terms of this plan. When you or a covered dependent is no longer eligible for county benefits, Vision Service Plan (VSP) will cover only those expenses for services authorized by VSP in a benefit authorization to a VSP provider before your loss of coverage and completed before the expiration date of the benefit authorization.

When Coverage Ends for You

Your health care coverage (medical, dental and vision) ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire or die;
- the day the plan terminates.

When Coverage Ends for Dependents

Health care coverage (medical, dental and vision) for your covered dependents ends on:

- the last day of the month they lose eligibility, your coverage ends or they die;
- the day the plan terminates.

How to Continue Coverage

If you or your eligible dependents lose county-paid health care coverage due to certain qualifying life events, each of you has an independent right to continue medical, dental and vision coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act). This coverage, which is paid entirely by you, may continue for 18 to 36 months after county-paid coverage ends, which is the last day of the month in which the qualifying life event occurs.

How to Convert Coverage

You may be able to convert your county health care coverage to an individual policy.

KingCare℠

WHAT IS "EVIDENCE OF INSURABILITY"?

"Evidence of insurability" is any statement or proof of a person's physical condition, occupation or other factor affecting his/her acceptance for insurance.

If you're no longer eligible for KingCare℠ coverage, you may convert your coverage to a Regence-insured plan without providing evidence of insurability (EOI). The plan you convert to will differ from your county KingCare℠ plan. If the plan includes a prescription drug benefit, claims will be processed by Regence, not by Express Scripts. You may not transfer your Express Scripts coverage to an insured conversion plan.

If you convert your coverage to a Regence-insured plan, you must pay premiums, which may be higher than the amount you currently pay (if any) for these benefits.

To apply for an individual policy, you must complete and return an application form to Regence within 31 days after your medical coverage ends. You will not receive the application or information about conversion coverage unless you request it from Regence.

Group Health

If you're no longer eligible for Group Health coverage, you may convert your coverage to an insured conversion plan without providing evidence of insurability (EOI). The plan you convert to will differ from your county Group Health plan. You must pay premiums, which may be higher than amounts you currently pay (if any) for this coverage.

You will not be able to convert coverage to an individual policy if you're eligible for any other medical coverage under any other group plan, including coverage under the Affordable Care Act or Medicare.

To apply for an individual policy, you must complete and return an application form to Group Health within 31 days after your medical coverage ends. You will not receive this application or information about conversion coverage unless you request it from Group Health.

Medical Plans

King County provides you with medical coverage that offers flexibility and choice. That way, you can choose the medical plan that's right for you.

Your Medical Plan Choices

As a benefit-eligible employee, you may be covered by one of two medical plans: KingCare℠ or SmartCare Connect.

KingCare℠

Medical benefits under KingCare℠ are administered by Regence; prescription benefits under the plan are administered by Express Scripts, Inc.

The medical and prescription drug benefits of the KingCare℠ plan are "self-funded" by King County. This means that the county is financially responsible for and pays all claims and other costs associated with KingCare℠.

Group Health

Medical and prescription benefits under the SmartCare Connect plan are administered by Group Health. Group Health is a health maintenance organization in the Pacific Northwest, with reciprocal agreements for out-of-area services with Kaiser Permanente.

The medical and prescription drug benefits of the KingCare℠ plan are "self-funded" by King County. This means that the county is financially responsible for and pays all claims and other costs associated with SmartCare Connect.

How the Healthy Incentives℠ Program Works

The Healthy Incentives℠ program supports healthy behavior and improved health outcomes for employees and their families while reducing the cost of health care for employees and King County.

Each year, you and your spouse/domestic partner have the opportunity to take a wellness assessment and participate in an individual action plan to support healthy behaviors.

Participation in the program is voluntary, but can reduce out-of-pocket expenses for you and your family. The out-of-pocket expense level you earn is based solely on participation in the program, not on a specific outcome or health condition.

Out-of-Pocket Expense Levels

Under the Healthy Incentives℠ program, there are three out-of-pocket expense levels in the KingCare℠ and Group Health plans:

- Gold—the lowest out-of-pocket expense level;
- Silver—the middle out-of-pocket expense level; and
- Bronze—the highest out-of-pocket expense level.

If you take the wellness assessment and complete an individual action plan by the deadline, you'll earn the Gold out-of-pocket expense level for the following year.

If you only take the wellness assessment by the deadline (and do not complete and individual action plan), you'll earn the Silver out-of-pocket expense level for the following year.

If you choose not to participate in the Healthy Incentives[SM] program, you'll receive the Bronze out-of-pocket expense level for the following year.

The out-of-pocket expense level for your family is based on the lowest level of participation by you and your spouse/domestic partner.

Benefit Access Fee

When you add a spouse/domestic partner to your medical coverage, you pay a monthly post-tax benefit access fee of $75 through payroll deduction for your spouse/domestic partner's county medical coverage if your spouse/domestic partner has access to medical coverage:

- through his/her own employer;
- through a union trust paid by an employer; or
- through the military while in active service.

You don't have to pay a benefit access fee if:

- you cover a spouse/domestic partner who is unemployed, a county employee, or covered under Medicare, Medicaid, retiree medical, COBRA (Consolidated Omnibus Budget Reconciliation Act) or disability (whether Social Security or military);
- your spouse/domestic partner has coverage because he/she is a veteran or retired from the military;
- your spouse/domestic partner has private coverage, Canadian coverage or other foreign government–supported coverage; or
- you elect coverage under the Group Health plan.

When you complete the online Marriage/Domestic Partnership form to add your spouse/domestic partner to your county benefits, you are asked to elect a benefit access fee option. If you meet one of the criteria for not being charged the benefit access fee and you elect that option, you will not be charged the benefit access fee. If you don't make an election, the benefit access fee is automatically deducted from your paycheck. You may later ask that the benefit access fee deduction be discontinued, but any fees already deducted will not be refunded.

Your Medical Benefits at a Glance

This section provides a quick overview of your KingCare℠ and SmartCare Connect benefits.

KingCare℠ Benefits at a Glance

The following tables show what KingCare℠ pays for covered expenses, depending on whether you receive the Gold, Silver or Bronze out-of-pocket expense level.

Plan Features

The following table identifies some plan features, including your annual deductibles, out-of-pocket maximums and how benefits are determined for most covered expenses.

Plan Feature	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Provider choice	You may choose any qualified provider, but you receive higher coverage when you use network providers. Reimbursement for out-of-network medical services is based on reasonable and customary (R&C) rates, and reimbursement for out-of-network prescription drug services is based on the rates Express Scripts pays its network pharmacies. You pay amounts in excess of these rates.		
Annual deductible	$300/person; $900/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**	$600/person; $1,800/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**	$800/person; $2,400/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**
Copays	Applicable only to emergency room care and prescription drugs		
After the deductible/copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 85% (You pay 15% coinsurance) Out-of-network: 65% (You pay 35% coinsurance) 100% of network rate after applicable copays for prescription drug claims (Deductible doesn't apply)	Network: 75% (You pay 25% coinsurance) Out-of-network: 55% (You pay 45% coinsurance) 100% of network rate after applicable copays for prescription drug claims (Deductible doesn't apply)	Network: 75% (You pay 25% coinsurance) Out-of-network: 55% (You pay 45% coinsurance) 100% of network rate after applicable copays for prescription drug claims (Deductible doesn't apply)

Plan Feature	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Annual out-of-pocket maximum for medical services	Network: $800/person or $1,600/family, plus deductible Out-of-network: $1,600/person or $3,200/family, plus deductible Doesn't apply to prescriptions	Network: $1,000/ person or $2,000/ family, plus deductible Out-of-network: $1,800/ person or $3,600/ family, plus deductible Doesn't apply to prescriptions	Network: $1,200/ person or $2,400/ family, plus deductible Out-of-network: $2,000/person or $4,000/family, plus deductible Doesn't apply to prescriptions
Annual out-of-pocket maximum for prescription drugs	$1,500/person or $3,000/family		
After you reach the out-of-pocket maximum for medical services, most benefits are paid for the rest of the calendar year at this level	Network: 100% Out-of-network: 100% of R&C charges		
Lifetime maximum	No limit		

Covered Expenses

The following table summarizes covered services and supplies under KingCare℠ (only medically necessary services, prescription drugs and supplies are covered) and identifies related coinsurance, copays, maximums and limits.

Regence processes medical claims and inpatient prescription drug claims; Express Scripts processes outpatient retail pharmacy and mail-order prescription drug claims. Where a benefit involves claims processed by both Regence and Express Scripts, you'll find information in the following table.

IMPORTANT!

Before you receive out-of-network care, be sure you understand how covered out-of-network expenses are paid. All covered out-of-network expenses are paid based on reasonable and customary (R&C) charges, as determined by the plan. That means if you go to an out-of-network provider and the charges are more than R&C charges for those services, **you** pay the additional charges. (For important details about R&C charges, see "Reasonable and Customary (R&C) Charges").

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Alternative care (including medically necessary acupuncture and massage therapy)	Network: 85% Out-of-network: 65% Massage therapy does not require a prescription from a physician. A total of 60 covered visits/year (may include any combination of acupuncture and/or massage therapy visits)	Network: 75% Out-of-network: 55% Massage therapy does not require a prescription from a physician. A total of 60 covered visits/year (may include any combination of acupuncture and/or massage therapy visits)	Network: 75% Out-of-network: 55% Massage therapy does not require a prescription from a physician. A total of 60 covered visits/year (may include any combination of acupuncture and/or massage therapy visits)
Ambulance services	Network: 85% Out-of-network: 85%	Network: 75% Out-of-network: 75%	Network: 75% Out-of-network: 75%
Applied behavioral analysis therapy for autism-spectrum disorders (requires preauthorization)	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Chemical dependency treatment—inpatient and outpatient (requires preauthorization)	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Detoxification (medically necessary)	Network: 85% Out-of-network: 85%	Network: 75% Out-of-network: 75%	Network: 75% Out-of-network: 75%
Diabetes care training	Network: 100% when prescribed by your physician Out-of-network: 65% when prescribed by your physician	Network: 100% when prescribed by your physician Out-of-network: 55% when prescribed by your physician	Network: 100% when prescribed by your physician Out-of-network: 55% when prescribed by your physician
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs		
Durable medical equipment, prosthetics and orthopedic appliances	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Emergency room care (also see "Urgent Care")	Emergency care, network: 85% after $100 copay/visit (waived if admitted) Emergency care, out-of-network: 85% after $100 copay/visit (waived if admitted) Non-emergency care, network: 85% after $100 copay/visit Non-emergency care, out-of-network: 65% after $100 copay/visit	Emergency care, network: 75% after $100 copay/visit (waived if admitted) Emergency care, out-of-network: 75% after $100 copay/visit (waived if admitted) Non-emergency care, network: 75% after $100 copay/visit Non-emergency care, out-of-network: 55% after $100 copay/visit	Emergency care, network: 75% after $100 copay/visit (waived if admitted) Emergency care, out-of-network: 75% after $100 copay/visit (waived if admitted) Non-emergency care, network: 75% after $100 copay/visit Non-emergency care, out-of-network: 55% after $100 copay/visit
Family planning	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Growth hormones—when administered by a health care provider	Covered under prescription drugs		
Hearing aids	100%, up to $500 every three calendar years for combined network and out-of-network services No dollar limit for cochlear implants Deductible doesn't apply Benefit limits reset every three calendar years, beginning 1/1/2015, regardless of when you join the plan		
Home health care	100%, up to 130 visits/year for combined network and out-of-network services		
Hospice care	100% Deductible applies		
Hospital care (contact the plan for services requiring preauthorization)	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Infertility	Network: 85% Out-of-network: 65% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services	Network: 75% Out-of-network: 55% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services	Network: 75% Out-of-network: 55% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services
Injury to teeth (only accidental injury covered—injury from biting and chewing not covered)	Network: 85% Out-of-network: 65% Treatment must be provided within 12 months of date of injury, except for children under age 14.	Network: 75% Out-of-network: 55% Treatment must be provided within 12 months of date of injury, except for children under age 14.	Network: 75% Out-of-network: 55% Treatment must be provided within 12 months of date of injury, except for children under age 14.
Inpatient care alternatives	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized
Jaw abnormalities, bone grafts or malocclusions (covered when medically necessary)	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized
Lab, X-ray and other diagnostic testing	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Maternity care	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Mental health care—inpatient and outpatient	Network: 85% Out-of-network: 65% No limit on number of days or visits.	Network: 75% Out-of-network: 55% No limit on number of days or visits.	Network: 75% Out-of-network: 55% No limit on number of days or visits.
Naturopathy	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Neurodevelopmental therapy	Network: 85% Out-of-network: 65% when preauthorized	Network: 75% Out-of-network: 55% when preauthorized	Network: 75% Out-of-network: 55% when preauthorized
Obesity surgery or other procedures, treatment or services, such as gastric intestinal bypass surgery	Network: 85% when preauthorized and medically necessary Out-of-network: 65% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization	Network: 75% when preauthorized and medically necessary Out-of-network: 55% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization	Network: 75% when preauthorized and medically necessary Out-of-network: 55% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization
Out-of-area coverage—for example, while traveling or for your covered children away at school	Same coverage as when home, through Regence and Express Scripts national provider networks		
Phenylketonuria (PKU) formula	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Physician and other medical/surgical services	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Prescription drugs—up to a 30-day supply through network pharmacies	Generic: 100% after $7 copay Preferred brand: 100% after $30 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $22 copay—see "Preventive Care" under "What's Covered and What's Not" for more information) Non-preferred brand: 100% after $60 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $45 copay) Prescriptions filled at out-of-network pharmacies are reimbursed at the rate Express Scripts pays to network pharmacies, less your copay.		

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Prescription drugs—up to a 90-day supply through mail-order network only	Generic: 100% after $14 copay Preferred brand: 100% after $60 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $44 copay—see "Preventive Care" under "What's Covered and What's Not" for more information) Non-preferred brand: 100% after $120 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $90 copay)		
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)	Network: 100% Out-of-network: 65% Deductible doesn't apply, but coverage is based on specific schedules.	Network: 100% Out-of-network: 55% Deductible doesn't apply, but coverage is based on specific schedules.	Network: 100% Out-of-network: 55% Deductible doesn't apply, but coverage is based on specific schedules.
Radiation therapy, chemotherapy and respiratory therapy	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—call plan for more information.	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%
Rehabilitative services—inpatient and outpatient	Network: 85% Out-of-network: 65% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined	Network: 75% Out-of-network: 55% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined	Network: 75% Out-of-network: 55% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined
Skilled nursing facility	Network: 85% when preauthorized Out-of-network: 65% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized	Network: 75% when preauthorized Out-of-network: 55% when preauthorized

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Smoking cessation	Network: 100% Deductible doesn't apply Out-of-network: Not covered Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Regence at 100%	Network: 100% Deductible doesn't apply Out-of-network: Not covered Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Regence at 100%	Network: 100% Deductible doesn't apply Out-of-network: Not covered Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Regence at 100%
Spinal manipulations ***(like all services, must be medically necessary)***	Network: 85% Out-of-network: 65% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders	Network: 75% Out-of-network: 55% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders	Network: 75% Out-of-network: 55% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders
Temporomandibular joint (TMJ) disorders	Network: 85% when preauthorized Out-of-network: 65% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder	Network: 75% when preauthorized Out-of-network: 55% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder	Network: 75% when preauthorized Out-of-network: 55% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder
Transgender surgical services (preauthorization required)	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%

Covered Expenses	KingCare℠ Gold	KingCare℠ Silver	KingCare℠ Bronze
Transplants (certain services only)	Network: 100% when preauthorized Out-of-network: 65% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered	Network: 100% when preauthorized Out-of-network: 55% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered	Network: 100% when preauthorized Out-of-network: 55% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered
Urgent care (ear infections, high fevers, minor burns, etc.)	Network: 85% Out-of-network: 65%	Network: 75% Out-of-network: 55%	Network: 75% Out-of-network: 55%

Group Health Benefits at a Glance

The following tables show what Group Health pays for covered expenses, depending on whether you have the Gold, Silver or Bronze out-of-pocket expense level.

There's no coverage for out-of-network care unless it has been indicated and approved/referred.

Plan Features

The following table identifies some plan features, including copays, out-of-pocket maximums and how benefits are determined for most covered expenses.

Plan Feature	Group Health Gold	Group Health Silver	Group Health Bronze
Provider choice	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There's no coverage for out-of-network care unless indicated and approved/referred.		
Annual deductible	None		
Copay, unless otherwise indicated	You pay $20	You pay $35	You pay $50
After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 100% Out-of-network: Limited emergency/out-of-area care		
Annual out-of-pocket maximum	Network: $1,000/ person or $2,000/ family Out-of-network: Limited emergency/out-of-area care	Network: $2,000/ person or $4,000/ family Out-of-network: Limited emergency/out-of-area care	Network: $3,000/ person or $6,000/ family Out-of-network: Limited emergency/out-of-area care
After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	Network only: 100%		
Lifetime maximum	No limit		

Covered Expenses

The following table summarizes covered services and supplies under Group Health (only medically necessary services, prescription drugs and supplies are covered) and identifies related copays, maximums and limits.

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)	Self-referrals to a network provider: $20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral	Self-referrals to a network provider: $35 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral	Self-referrals to a network provider: $50 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral
Ambulance services	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)		
Applied behavioral analysis therapy for autism-spectrum disorders—outpatient	$20 copay No limit on number of days or visits No age limit	$35 copay No limit on number of days or visits No age limit	$50 copay No limit on number of days or visits No age limit
Chemical dependency treatment—inpatient and outpatient (requires preauthorization)	*For inpatient care:* 100% after $200 copay/admission *For outpatient care:* 100% after $20 copay/visit No limit	*For inpatient care:* 100% after $400 copay/admission *For outpatient care:* 100% after $35 copay/visit No limit	*For inpatient care:* 100% after $600 copay/admission *For outpatient care:* 100% after $50 copay/visit No limit
Diabetes care training	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	50% when preauthorized	50% when preauthorized

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Emergency room care	Network: 100% after $100 copay/visit ($100 copay is waived, but $200 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived but $200 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered**	Network: 100% after $100 copay/visit ($100 copay is waived, but $400 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived, but $400 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered**	Network: 100% after $100 copay/visit ($100 copay is waived, but $600 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived, but $600 copay/admission for hospital care applies if admitted) **Non-emergency care is not covered**
Family planning	100% after $20 copay/visit **Infertility treatment is not covered**	100% after $35 copay/visit **Infertility treatment is not covered**	100% after $50 copay/visit **Infertility treatment is not covered**
Growth hormones	Covered under prescription drug benefit with applicable copay when medically necessary		
Hearing aids	100%, up to $300 allowance/ear during a period of 3 consecutive years No dollar limit for cochlear implants		
Home health care	100%		
Hospice care	100% Deductible doesn't apply		
Hospital care (contact the plan for services requiring preauthorization)	100% after $200 copay/admission	100% after $400 copay/admission	100% after $600 copay/admission
Injury to teeth (only accidental injury covered—injury from biting and chewing not covered)	100% after $20 copay/visit Treatment must be provided within 12 months of date of injury, except for children under age 14	100% after $35 copay/visit Treatment must be provided within 12 months of date of injury, except for children under age 14	100% after $50 copay/visit Treatment must be provided within 12 months of date of injury, except for children under age 14
Inpatient care alternatives	100% when preauthorized		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Lab, X-ray and other diagnostic testing	100%		
Maternity care	*For delivery and related hospital care:* 100% after $200 copay/admission *For prenatal and postpartum care:* 100% after $20 copay/visit	*For delivery and related hospital care:* 100% after $400 copay/admission *For prenatal and postpartum care:* 100% after $35 copay/visit	*For delivery and related hospital care:* 100% after $600 copay/admission *For prenatal and postpartum care:* 100% after $50 copay/visit
Mental health care—inpatient and outpatient	*For inpatient care:* 100% after $200 copay per admission *For outpatient care:* 100% after $20 copay/individual, family, couple or group session No limit on number of days or visits	*For inpatient care:* 100% after $400 copay per admission *For outpatient care:* 100% after $35 copay/individual, family, couple or group session No limit on number of days or visits	*For inpatient care:* 100% after $600 copay per admission *For outpatient care:* 100% after $50 copay/individual, family, couple or group session No limit on number of days or visits
Neurodevelopmental therapy	*For inpatient care:* 100% after $200 copay/admission *For outpatient care:* 100% after $20 copay/ visit	*For inpatient care:* 100% after $400 copay/ admission *For outpatient care:* 100% after $35 copay/visit	*For inpatient care:* 100% after $600 copay/ admission *For outpatient care:* 100% after $50 copay/visit
Out-of-area coverage—for example, while traveling or for your covered children away at school	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.		
Phenylketonuria (PKU) formula	100%		
Physician and other medical/surgical services	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/office visit	*For inpatient care:* 100% *For outpatient care:* 100% after $35 copay/office visit	*For inpatient care:* 100% *For outpatient care:* 100% after $50 copay/office visit
Prescription drugs—up to a 30-day supply through network pharmacies	Generic: 100% after $10 copay Preferred brand: 100% after $20 copay Non-preferred brand: 100% after $30 copay There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies		
Prescription drug—up to a 90-day supply through mail-order network only	Generic: 100% after $20 copay Preferred brand: 100% after $40 copay Non-preferred brand: 100% after $60 copay		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)
Radiation therapy, chemotherapy and respiratory therapy	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—call plan for more information.	100% depending on services provided; copays may apply (including $200 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including $400 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including $600 copay/admission if hospital care is required)
Rehabilitative services—inpatient and outpatient	*For inpatient care:* 100% after $200 copay/admission, up to 60 days/calendar year *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/calendar year	*For inpatient care:* 100% after $400 copay/ admission, up to 60 days/calendar year *For outpatient care:* 100% after $35 copay/visit, up to 60 visits/calendar year	*For inpatient care:* 100% after $600 copay/ admission, up to 60 days/calendar year *For outpatient care:* 100% after $50 copay/visit, up to 60 visits/calendar year
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility		
Smoking cessation	100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Quit For Life® Program, when prescribed by Group Health PCP No annual or lifetime limit		
Spinal manipulations and manipulative therapy (like all services, must be medically necessary)	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Temporomandibular joint (TMJ) disorders	*For inpatient care:* 100% after $200 copay/admission *For outpatient care:* 100% after $20 copay/visit	*For inpatient care:* 100% after $400 copay/admission *For outpatient care:* 100% after $35 copay/visit	*For inpatient care:* 100% after $600 copay/admission *For outpatient care:* 100% after $50 copay/visit

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Transgender surgical services (preauthorization required for non-emergent inpatient hospital procedures)	100% when preauthorized	100% when preauthorized	100% when preauthorized
Transplants (certain services only)	100% after applicable copays Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered		
Urgent care (ear infections, high fevers, minor burns)	100% after $20 copay/visit	100% after $35 copay/visit	100% after $50 copay/visit
Vision exams	100% after $20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after $35 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after $50 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)

KingCare℠ (Regence)

To make the most out of the benefits available under KingCare℠, you need to understand how the plan works.

Accessing Care

When you're enrolled in KingCare℠, you may receive network benefits or out-of-network benefits. The level of coverage depends on the provider you see. You will pay less and won't have to file claims yourself if you see a provider in the Preferred or BlueCard PPO EPO networks. Visit www.regence.com/find-a-doctor to determine if your provider is in the network.

If Your Dependent Lives Away from Home

Covered dependents living away from home may use any network provider or pharmacy and receive the same coverage as if they were living at home.

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive medical coverage under your KingCare℠ insurance for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations.

Paying for Your Care

Network providers have agreed to provide care at negotiated rates. This means that the dollar amount you pay for your share of covered expenses when you see a network provider is generally lower than what you'll pay when you use an out-of-network provider.

The following describes the basic cost-sharing features of KingCare℠ with respect to how benefits are paid.

Deductible

IMPORTANT!

The amount you pay toward your deductible during the last three months of any calendar year will also apply toward the following year's deductible.

The "annual deductible" is the amount you must pay each year toward covered expenses before Regence begins paying. The KingCare℠ annual deductibles are as follows:

- KingCare℠ Gold: $300/person, $900/family;
- KingCare℠ Silver: $600/person, $1,800/family; and
- KingCare℠ Bronze: $800/person, $2,400/family.

The deductible doesn't apply to certain covered services and supplies, including prescription drugs (which require copays), preventive care and hearing aids.

Family Deductible

If three or more covered dependents (including yourself) together incur the total value of the family deductible for the plan in which you're enrolled, no further deductible will be required from any covered dependent for the rest of that year.

If you and your covered dependents are in the same accident, individual deductibles will be applied until the family deductible is met.

Coinsurance

After you've met your annual deductible, you begin paying a percentage "coinsurance" of the allowed amount for most medical services and supplies until you reach the annual out-of-pocket maximum. Coinsurance doesn't apply to prescription drugs.

Copay

You pay copays for prescription drugs at the time you receive your prescription. Copays don't apply to medical services other than emergency room care.

Reasonable and Customary (R&C) Charges

"Reasonable and customary charges" are rates that are consistent with those normally charged by a provider for the same services or supplies and within the general range of rates charged by other providers in the same area for the same services or supplies. When you use a network provider, you pay only the coinsurance on the charges that Regence has negotiated with the provider. When you use an out-of-network provider, Regence pays a percentage of the R&C charges, and you pay the remaining amount of the provider's charges.

Annual Out-of-Pocket Maximum

The "annual out-of-pocket maximum" is the most you pay in coinsurance for covered medical expenses each year. Once you reach your annual out-of-pocket maximum, KingCare[SM] pays 100% for most covered expenses for the rest of that year. If you have three or more covered dependents (including yourself), each dependent's covered expenses accumulate toward the family out-of-pocket maximum.

The following don't apply to the annual out-of-pocket maximum:

- amounts in excess of reasonable and customary (R&C) charges;
- annual deductible;
- charges above benefit maximums;
- copays for emergency room care; and
- expenses not covered under KingCare[SM].

Lifetime Maximum

There's no lifetime maximum benefit under KingCare[SM]. However, some expenses are subject to annual or lifetime benefit limits.

Other Features of KingCare[SM]

It's important to understand other features of KingCare[SM] such as preauthorization, second opinions, case management and health care management.

Preauthorization

Preauthorization refers to the process by which Regence determines that a proposed service or supply is medically necessary and provides approval for it before it is rendered.

Preauthorization is performed to ensure that the services you receive are aligned with evidence-based criteria and to determine whether the requested service meets Regence's medical necessity criteria. Preauthorization also ensures that services or supplies you receive are safe, effective, and appropriate, with the goal of helping you obtain the most out of your health plan benefits and receiving the right care, at the right time, and in the right place.

Network providers may be required to obtain preauthorization from Regence in advance for certain services provided to you. Out-of-network providers are not required to obtain preauthorization from the Claims Administrator in advance for services. You, however, may be liable for costs if you elect to seek services and those services are not considered medically necessary and/or not covered under this plan. You may request that an out of-network provider preauthorize services on your behalf to determine if they are medical necessity prior to the services being rendered.

A comprehensive list of services and supplies that must be preauthorized may be obtained from the Regence by visiting their Web site at: https://www.regence.com/web/regence_provider/pre-authorization or by contacting them directly.

Preauthorization requests should be faxed by your provider to Regence at 1 (877) 663-7526.

A list of prior authorization requirements may be found here: https://www.regence.com/web/regence_provider/commercial. Regence must be notified within 24 hours from the beginning of your admission, or as soon as reasonably possible, for:

- accidents;
- emergencies, including detoxification;
- involuntary commitment to a Washington state mental hospital; and
- inpatient hospital admissions, including maternity admissions.

To obtain preauthorization for non-emergency care or to obtain certification afterward, ask your physician to contact Regence.

When calling Regence, be prepared to supply these details:

- admission date;
- diagnosis or surgery;
- employer name (King County);
- employee name and unique identifying number assigned by KingCare[SM];
- hospital name and address or phone number;

- patient name, address and birth date;
- physician name and address or phone number; and
- proposed treatment plan, including length of stay and discharge planning needs.

If your care isn't preauthorized as described previously in this section and Regence determines that your care wasn't medically necessary, KingCare[SM] may pay only a portion of the charges or none at all.

Second Opinions

On occasion, you may want a second opinion from another physician regarding a medical diagnosis or treatment plan. To receive network benefits, you must obtain the second opinion from a Regence network provider. At any point, you may decide to see an out-of-network provider and receive out-of-network benefits.

Case Management

Regence may offer or approve other medical options on a case-by-case basis when the options are determined to be medically necessary, effective and cost-effective. These alternative options will be approved only when traditional benefits would otherwise be available under KingCare[SM]—for example, when provided at equal or lesser cost, benefits could be available for home health care, instead of hospitalization or other institutional care, by a licensed home health, hospice or home care agency. The amount of coverage for approved alternative options will not exceed the amount that would otherwise be available for approved traditional benefits.

Less expensive or less intensive services will be approved for alternative options only with your consent and when your physician confirms that the services are adequate. Regence may require an approved written treatment plan.

Knowing What's Covered and What's Not

It's possible that some medical treatments may not be covered under KingCare[SM]. The following provides guidelines of what is considered a "covered expense" and an "uncovered expense."

Covered Expenses

Only medically necessary services, supplies and prescription drugs are covered.

Alternative Care

Covered services, which must be medically necessary and/or prescribed by a health care provider, include:

- acupuncture;

- hypnotherapy services performed by a covered mental health provider specified under "Mental Health Care"; and
- massage therapy performed by a massage therapist.

You're eligible to receive a total of 60 covered alternative care visits/year. This may include any combination of acupuncture and/or massage therapy visits.

Ambulance Services

KingCare[SM] covers medically necessary emergency ground or air ambulance services to a network facility or the nearest facility where appropriate care is covered.

Applied Behavioral Analysis Therapy for Autism-spectrum Disorders

Applied behavioral analysis (ABA) therapy involves the design, implementation and evaluation of environmental modifications to produce socially significant improvement in human behavior. It also involves the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. ABA therapy must be preauthorized.

Eligible ABA therapy providers include:

- licensed and credentialed speech therapists, occupational therapists, psychologists, pediatricians, neurologists, psychiatrists, mental health counselors and social workers who are board-certified behavior analysts; and
- board-certified behavior analysts and therapy assistants working under the supervision of licensed, credentialed providers.

To be eligible for this coverage, the member must:

- have a referral for ABA therapy from a licensed health or mental health provider, such as a physician, psychologist or speech-language pathologist;
- have received a diagnosis of an autism-spectrum disorder by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism; and
- must be able to provide documented diagnostic assessments, individualized treatment plans and progress evaluations.

Coverage is provided at any age for the following conditions:

- autistic disorder, as defined by the *International Classification of Diseases*, *Ninth Revision;*
- Asperger's disorder; and
- pervasive developmental disorder.

Chemical Dependency Treatment

Covered inpatient and outpatient chemical dependency treatment includes:

- detoxification services;
- diagnostic evaluation and education;
- organized individual and group counseling; and
- prescription drugs.

Medically necessary detoxification services for alcoholism and drug abuse are covered as an Emergency Medical Condition and does not require pre-authorization or pre-notification.

Regence network providers obtain preauthorization for chemical dependency treatment as necessary. If you see an out-of-network provider, they are not required to seek prior authorization on your behalf, though you may request they do so. You may be liable for costs if you elect to seek services that are not medically necessary.

For additional counseling and referral services, you may also contact the Making Life Easier Program.

Regence processes claims for prescription drugs used during inpatient hospitalization. Express Scripts processes claims for outpatient retail pharmacy and mail-order drugs.

Diabetes Care Training

KingCare[SM] covers diabetes care training when prescribed by and supervised by your physician as part of a self-care program. The program must consist of services recognized by health care professionals and be designed to educate you about specific conditions and any lifestyle changes necessary as a result of your diabetes condition. Reasonable charges include individual or group educational services, tuition, supplies and appropriate diagnostic services.

Durable Medical Equipment, Prosthetics and Orthopedic Appliances

Durable medical equipment is covered if it:

- is designed for prolonged use;
- has a specific therapeutic purpose in treating an illness or injury;
- is prescribed by your physician; and
- is primarily and customarily used for medical purposes only.

Network providers will obtain preauthorization for your care as necessary. If you see an out-of-network provider, they are not required to seek prior authorization on your behalf, though you may request they do so. You may be liable for costs if you elect to seek services that are not medically necessary.

Medical Services. KingCare[SM] covers the following durable medical equipment:

- artificial limbs or eyes, including implant lenses prescribed by your physician and required as the result of cataract surgery or to replace a missing portion of the eye;
- casts, splints, crutches, trusses and braces;
- CPAP machines and associated supplies, as determined necessary by a sleep study; diabetes equipment, excluding batteries, for home testing and insulin administration not covered under the prescription drug benefit;
- phototherapy using a high-intensity light box for the treatment of seasonal affective disorder, bipolar disorder or recurrent major depression when the diagnosis meets Regence's criteria for coverage;

- initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery;
- oxygen and rental equipment for its administration;
- penile prosthesis, with a lifetime maximum of two prostheses, when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery, or an injury to the genitalia or spinal cord, and other accepted treatment has been unsuccessful;
- rental or purchase, as decided by Regence, of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price); and
- wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100.

Prescription Drug Services. Some durable medical equipment is covered through Express Scripts.

Emergency Room Care

Emergency room treatment is covered only for medical conditions that threaten loss of life or limb or may cause serious harm to the patient's health if not done immediately. Examples of conditions that might require emergency room care include, but are not limited to:

- chest pain;
- convulsions;
- major burns;
- severe breathing problems;
- unconsciousness or confusion, especially after a head injury; and
- uncontrollable bleeding.

If you need emergency room care, follow these steps:

- call 911 or go to the nearest hospital emergency room immediately.
- when you arrive, show your medical plan ID card.
- if possible, call Regence within 24 hours using the phone number printed on the front of your ID card; otherwise, you may receive a reduced benefit.
- if you're incapable of calling Regence, ask a friend, relative or hospital staff member to call for you.

When you visit an emergency room, you may receive some services from network providers and other services from out-of-network providers. For example, you may visit an emergency room in a network hospital that uses some out-of-network providers, such as anesthesiologists, emergency room physicians, assistant surgeons, radiologists and pathologists.

When you receive emergency room care services from network providers, you pay the network level of coinsurance on the charges Regence has negotiated with the providers. When you receive services from out-of-network providers, you pay the network level of coinsurance on the billed charges, which may be higher than charges negotiated with network providers. However, this coverage is different than most out-of-network care in which Regence pays a percentage of reasonable and customary (R&C) charges and you're responsible for paying any remaining charges.

If your condition doesn't qualify as a medical emergency but care is urgently needed, see "Urgent Care" for a description of coverage.

Family Planning

Medical Services. KingCare[SM] covers the following family planning services:

- insertion or removal of intrauterine birth control devices (IUDs);
- tubal ligation;
- vasectomy; and
- voluntary termination of pregnancy (abortion).

Prescription Drug Services. Birth control pills and devices requiring a prescription are covered and processed by Express Scripts.

Growth Hormones

Growth hormones are covered under the Prescription Benefit Plan for certain medical conditions and must be preauthorized whether you receive network or out-of-network care. If you receive this drug from your physician, he/she will bill Express Scripts for the drug and its administration. If you obtain the drug from a retail pharmacy or mail-order service, Express Scripts pays for the drug and for administration by your physician, if needed.

Hearing Aids

Hearing aids, including fitting, rental and repair, are covered.

Home Health Care

Home health care services are covered if care:

- takes the place of a hospital stay;
- is part of a home health care plan; and
- is provided and billed by an organization licensed as a home health care agency by the State of Washington.

Covered services include:

- nursing care;
- occupational therapy;
- physical therapy;
- respiratory therapy;

- restorative therapy; and
- speech therapy (restorative only).

Services and prescription drugs provided and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health care agency. The prescription drug claims are processed by Express Scripts when they're filled at a retail pharmacy or through the mail-order service.

Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician, nurse, medical social worker or physical, speech, occupational or respiratory therapist.

Services are covered if care:

- takes the place of a hospital stay;
- is part of a hospice care treatment plan; and
- is provided and billed by an organization licensed as a hospice by the State of Washington.

Covered services include:

- drugs and medications (Regence processes claims for prescription drugs provided by the hospice during the course of medical treatment, and Express Scripts processes claims for retail pharmacy and mail-order drugs);
- emotional support services;
- family bereavement services;
- home health services;
- homemaker services, if appropriate to patient's direct care;
- inpatient hospice care;
- physician services; and
- respite care for dependents providing care for the patient.

An extension of these benefits beyond the 12-month lifetime maximum may be granted if Regence receives a written request from your physician.

Hospital Care

Inpatient Care. Covered inpatient hospital care includes:

- hospital services such as:
  - anesthesia and related supplies administered by hospital staff;
  - artificial kidney treatment;
  - blood, blood plasma and blood derivatives;
  - drugs provided by the hospital in the course of medical treatment;

  - electrocardiograms;
  - operating rooms, recovery rooms, isolation rooms and cast rooms;
  - oxygen and its administration;
  - physiotherapy and hydrotherapy;
  - splints, casts and dressings;
  - X-ray, radium and radioactive isotope therapy; and
  - X-ray and lab exams;
- intensive care or coronary care units;
- newborn nursery care after covered childbirth, including circumcision; and
- semi-private room, patient meals and general nursing care (private room charges are covered only up to the hospital's semi-private room rate).

Notice to Regence within 24 hours is required for most inpatient hospital stays.

If a hospital stay continues from one calendar year to the next, a second deductible isn't required for further treatment before discharge. Coverage continues at 100% until discharge, if the out-of-pocket maximum is met for the year in which hospitalization began.

If you or your covered dependent is hospitalized and your medical coverage ends, the plan continues to provide hospital care coverage until discharge. Coverage ends on the date of discharge or when you or your covered dependent reaches the plan maximum, whichever comes first.

Outpatient Care. Covered outpatient care includes:

- diagnostic and therapeutic nuclear medicine in a hospital setting;
- hospital outpatient chemotherapy to treat malignancies;
- outpatient surgery; and
- surgery in an ambulatory surgical center in place of inpatient hospital care.

Infertility

Covered infertility expenses include:

- embryo transfer;
- intrauterine and intravaginal artificial insemination; and
- in vitro fertilization.

Injury to Teeth

The services of a licensed dentist are covered for the repair of accidental injury to sound, natural teeth. Injures caused by biting or chewing are not covered. All services must be provided within 12 months of the date of injury. The treatment period for a child under age 14 will be expanded to allow the child to reach a point of development where treatment will be effective; however, the child will only be eligible to receive the treatment if he/she was covered at the time of the accident and remains continuously covered through the time period in which the treatment is provided.

Inpatient Care Alternatives

Your physician may develop a written treatment plan for care in an equally or more cost-effective setting than a hospital or skilled nursing facility. If the alternative setting plan is approved by Regence, all hospital or skilled nursing facility benefit terms, maximums and limits apply to the inpatient care alternatives, depending on the kind of care the alternative is intended to replace.

Jaw Abnormalities

Covered services include:

- surgical corrections of jaw abnormalities, or malocclusions, when medically necessary; and
- bone grafts for dental implants when medically necessary to provide support to the implants and the jaw (e.g., in cases of osteoporosis).

Lab, X-ray and Other Diagnostic Testing

Covered services include:

- lab or X-ray services such as ultrasound, nuclear medicine and allergy testing;
- screening and diagnostic procedures during pregnancy, as well as related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders;
- services provided by a physician or licensed optometrist to diagnose or treat medical conditions of the eye (eyewear and routine vision exams and tests for vision sharpness are covered under your vision plan); and
- services provided by a physician to diagnose gastrointestinal conditions.

Maternity Care

Maternity care is covered if provided by:

- a physician or registered nurse whose specialty is midwifery; or
- a midwife licensed by the State of Washington.

Covered maternity care includes:

- complications of pregnancy or delivery;
- hospitalization and delivery, including home births and licensed birthing centers for low-risk pregnancies;
- postpartum care;

- pregnancy care;
- related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders; and
- screening and diagnostic procedures during pregnancy.

The plan covers maternity care for covered dependent children and provides coverage for the newborn of the covered dependent child for three weeks.

HOSPITAL STAYS AND FEDERAL LAW

Group medical plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally doesn't prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and insurers may not require a provider to obtain authorization for prescribing a stay that doesn't exceed 48 hours or 96 hours, as applicable.

You don't need to preauthorize the length of stay.

Mental Health Care

Mental health care services are covered at the same coinsurance rates as other medical care and are applied against your annual out-of-pocket maximum.

Inpatient and outpatient mental health care is covered if provided by a:

- licensed psychiatrist (MD);
- licensed psychologist (PhD);
- licensed master's-level mental health counselor (LMHC);
- licensed nurse practitioner (ARNP);
- community mental health agency licensed by the Department of Health; or
- licensed state hospital.

For additional counseling and referral services, you may also call the Making Life Easier Program.

Covered services include:

- individual and group psychotherapy;
- inpatient care or day-treatment care instead of hospitalization (must be in a licensed medical facility);
- lab services related to the covered provider's approved treatment plan;
- marriage and family therapy;
- physical exams and intake history; and
- psychological testing.

Depending on individual medical needs, other benefit options may be available under the KingCare[SM] case management program.

If you see an out-of-network provider, they are not required to seek prior authorization on your behalf, though you may request they do so. You may be liable for costs if you elect to seek services that are not medically necessary.

Naturopathy

KingCare[SM] covers the following naturopathic services:

- immunization agents or biological sera, such as allergy serum;
- medical care in the provider's office;
- nutritional counseling by a licensed nutritionist or dietitian when medically necessary for disease management;
- physician services for surgery and anesthesia, and home, office, hospital and skilled nursing facility visits; and
- second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training); a second opinion may be required to confirm the medical necessity of a proposed surgery or treatment plan.

Neurodevelopmental Therapy

KingCare[SM] covers inpatient and outpatient neurodevelopmental therapy services only if the care is:

- furnished by providers authorized to deliver occupational therapy, speech therapy and physical therapy;
- prescribed by the patient's physician, and
- provided to restore and improve the child's ability to function.

Newborn Care

KingCare[SM] covers newborns under the mother's health plan for the first three weeks, as required by Washington state law. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled using benefit enrollment forms.

Obesity Surgery

Obesity surgery or other procedures, treatment or services, such as gastric intestinal bypass surgery, are covered only if proven medically necessary according to Regence Medical Policy. You must obtain preauthorization for this coverage. However, before you can obtain preauthorization, you must successfully complete a physician-supervised weight management and exercise program.

Phenylketonuria (PKU) Formula

KingCare[SM] covers the medical dietary formula that treats PKU. Claims are processed through Regence.

Physician and Other Medical/Surgical Services

KingCare[SM] covers the following services:

- immunization agents or biological sera, such as allergy serum;
- medical care in the provider's office;
- nutritional counseling by a licensed nutritionist or dietitian when medically necessary for disease management;
- physician services for surgery and anesthesia, and home, office, hospital and skilled nursing facility visits;
- second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training); a second opinion may be required to confirm the medical necessity of a proposed surgery or treatment plan; and
- sleep studies.

Prescription Drugs

Information about your prescription drug coverage is available under "Using Your Prescription Drug Plan."

You may be allowed to pay a lower copay for preferred brands or non-preferred brands if the following criteria are met:

- the brand is available from multiple manufacturers;
- your physician or pharmacy requests the lower copay;
- you have tried the generic equivalent and it has not been effective; and
- your physician writes a prescription for the brand using the notation, "dispense as written."

Preventive Care

KingCare[SM] covers the following preventive care services:

- breast exams, pelvic exams and Pap tests every year for women;
- mammograms every year for women over 40, or as determined by a provider for high-risk patients;
- cervical screening every year; or according to the following schedule:
  - if sexually active, every 1-2 years beginning at 21 years of age or earlier;
  - if 30 years of age and older, either a Pap test every 2 to 3 years after 3 consecutive normal results or HPV DNA test plus a Pap test every 3 years if results of both tests are negative; or
  - women 70 years of age and older may stop screening.
- diagnostic screening for prostate cancer as recommended by a physician, registered nurse or physician assistant; annual exams are recommended at age 40 and older;

- colorectal screening for colon cancer as recommended by a physician for individuals age 50 and older and for younger high-risk individuals; covers:
  - one annual fecal occult blood test;
  - one digital rectal exam and flexible sigmoidoscopy every 3 years;
  - one digital rectal exam and double-contrast barium enema every 3 years; and
  - one digital rectal exam and colonoscopy every 3 years;
- cholesterol screening every 3 years for men 35 and older, and every 3 years for women 45 and older;
- immunizations, including the one-time zoster (shingles) vaccine at age 55 or older and annual flu shots or nasal spray (immunizations for travel are not covered); and
- routine physicals and hearing tests.

Immunizations, routine physicals and hearing tests are covered according to the following schedule. The schedule is a guideline; benefits may be available more frequently depending on your health care needs. Before scheduling a routine physical, confirm with Regence that your physical will be covered.

Age	Preventive Care
Birth to 1 year	Routine newborn care, plus 7 well-baby office exams
1–2 years	3 well-child exams
2–3 years	3 well-child exams
4–6 years	3 well-child exams, with 1 in each of these age groups: 3–4, 4–5, 5–6
6–12 years	7 well-child exams, with 1 exam per year
13–17 years	5 well-teen exams, with 1 exam per year
18–25 years	1 well-adult exam every 2 years
26–49 years	1 well-adult exam every 2 years
50–64 years	1 well-adult exam every 2 years
65 years and older	1 well-adult exam every year

Sometimes when you have a routine preventive care office visit, your provider may request additional diagnostic services. In these situations when a non-routine diagnostic service is performed at the time of a routine preventive care visit, Regence will cover the additional diagnostic services under normal plan benefits while continuing to cover the preventive care portion of the visit at 100%.

Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for medically necessary radiation, chemotherapy and respiratory therapy when prescribed by your physician.

Reconstructive Services

Reconstructive surgery to improve or restore bodily function is covered, subject to Regence's review and approval. KingCare[SM] covers cosmetic surgery to improve physical appearance only if it's medically necessary.

KingCare[SM] covers the following services if the patient is receiving benefits for a mastectomy and elects breast reconstruction in connection with the mastectomy, as determined in consultation with the attending physician:

- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas;
- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other medical and surgical benefits.

Rehabilitative Services

KingCare[SM] covers medically necessary inpatient and outpatient rehabilitative care, including physical, occupational and speech therapy, designed to restore and improve a physical function lost due to a covered illness or injury. This care is considered medically necessary only if significant improvement in the lost function occurs while the care is provided and the attending physician expects significant improvement to continue. To verify whether coverage for rehabilitative services applies or continues to apply, Regence has the right to obtain written opinions from the attending physician concerning whether and to what extent the significant improvement is occurring.

Skilled Nursing Facility

Skilled nursing facility services are covered if:

- they're provided and billed by an organization licensed as a skilled nursing facility by the State of Washington; and
- the care takes the place of a hospital stay.

Let your provider know a written plan of treatment is required for these services to be covered. Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider, they are not required to seek prior authorization on your behalf, though you may request they do so. You may be liable for costs if you elect to seek services that are not medically necessary.

Prescription drugs are covered through Regence when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care. Outpatient, retail pharmacy and mail-order drugs are covered through Express Scripts.

Smoking Cessation

KingCare[SM] covers the following smoking cessation services (network only):

- acupuncture to ease nicotine withdrawal;
- hypnotherapy to ease nicotine withdrawal;

- non-prescription nicotine patches, lozenges and gum, which are covered at 100% through Regence;
- prescription drugs to ease nicotine withdrawal, inhalers and sprays, which are covered at 100% through Express Scripts; and
- smoking cessation programs (network only).

Additional help for smoking cessation is available through:

- Quit For Life®, a smoking cessation program covered at 100%, offers a variety of support options and educational materials. For more information, go to the Quit For Life® website or call 1-866-QUIT-4-LIFE (1-866-784-8454).

Spinal Manipulations

KingCare℠ covers the services of licensed chiropractors for the diagnosis and treatment of musculoskeletal disorders, including:

- diagnostic lab services directly related to the spinal care treatment you're receiving;
- full spinal X-rays; and
- non-invasive spinal manipulations.

Temporomandibular Joint (TMJ) Disorders

Diagnosis and treatment of TMJ and myofascial pain, including night guards when prescribed by a medical doctor due to a TMJ diagnosis, are covered as a medical condition. Out-of-network services must be preauthorized and in general use and acceptance by the medical/dental community to relieve symptoms, promote healing, modify behavior and stabilize the condition.

Additional benefits are available through the dental plan.

Transgender Surgical Services

KingCare℠ covers surgical services related to gender change, when preauthorized. Associated cosmetic surgery is not covered. Covered services include:

- mastectomy/breast reduction;
- hysterectomy;
- salpingo-oophorectomy;
- colpectomy;
- metoidioplasty;
- vaginoplasty;
- colovaginoplasty;
- orchiectomy;
- penectomy;
- clitoroplasty; and
- labiaplasty.

Transplants

KingCare[SM] covers professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care, as well as certain donor expenses, related to transplants. Benefits may include travel and accommodations (food costs are not covered) for someone to accompany a transplant recipient (the recipient's companion can be anyone of the recipient's choosing) and up to $100 a day for the companion's lodging (food costs are not covered). If the recipient is 18 years or younger, he/she may be accompanied by two parents or guardians.

The companion's lodging expenses are covered when the companion's presence is required to enable the recipient to receive services on either an inpatient or an outpatient basis.

Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider, they are not required to seek prior authorization on your behalf, though you may request they do so. You may be liable for costs if you elect to seek services that are not medically necessary.

You're not covered for organ transplant benefits until the first day of the 13th month of continuous coverage under KingCare[SM].

If your physician recommends a transplant, even if it's not listed in this section, call Regence immediately to discuss your situation and determine if the transplant is covered. If it is covered, you may make the necessary arrangements.

The following human transplants are covered:

- heart;
- lung;
- heart/lung;
- pancreas;
- kidney;
- simultaneous pancreas and kidney (SPK);
- liver;
- intestine;
- bone marrow/stem cell transplant;
- tandem transplants (stem cell);
- multiple organs replaced during one transplant surgery;
- sequential transplants;
- re-transplant of the same organ type within 180 days of the first transplant; and
- any other single organ transplant, unless otherwise excluded under the plan.

Transplant Recipients. If you're a transplant recipient, all of your services and supplies, including transportation, are covered.

Transplant Donor. Transplant donor expenses are covered if the recipient is a plan member. Covered services include:

- bone marrow testing and typing of the spouse, brothers, sisters, parents and children of the patient who needs the transplant (testing and typing of any other potential donor are not covered);
- evaluation of the donor organ or bone marrow, its removal and transport of both the surgical/harvesting team and donor organ or bone marrow, if used for a covered transplant; and
- activation of the donor search process for donors in the registry, HLA-DR sample procurement and typing, donor physical examinations and laboratory tests, and bone marrow/stem cell procurement.

Urgent Care

KingCare[SM] covers treatment for conditions that aren't considered a medical emergency but may need immediate medical attention. Examples of urgent conditions include:

- ear infections;
- high fevers; and
- minor burns.

If you need urgent care during office hours, call your physician's office for assistance. After office hours, call your physician's office and contact the on-call physician. Depending on your situation, the physician may provide instructions over the phone, ask you to come into the office or advise you to go to the nearest emergency room.

Expenses Not Covered

KingCare[SM] doesn't cover the following services:

- alternative care (including acupuncture, hypnotherapy and massage therapy) if it's not medically necessary;
- applied behavioral analysis therapy expense for autism-spectrum disorders involving:
  - baby sitting or doing household chores;
  - time spent under the care of any other professional;
  - travel time or care time;

  - home schooling in academics or other academic tutoring;
  - rehabilitative services (may be covered under the rehabilitative benefit); and
  - mental health services (may be covered under the mental health, substance abuse and alcoholism treatment benefit);
- benefits covered by the following agencies or programs, or benefits that would be covered by these agencies or programs if KingCare℠ didn't cover them, except as required by law:
  - any federal, state or government program (except for facilities in Regence's list of network providers);
  - government facilities outside the service area;
  - Medicare; and
  - workers' compensation or state industrial coverage;
- benefits payable under any automobile, medical personal injury protection, homeowner, commercial premises coverage or similar contract (reimbursement to Regence is made without reduction for any attorneys' fees, except as specified in the contract);
- biofeedback, if it's not medically necessary;
- charges exceeding reasonable and customary (R&C) rates;
- charges that, without this plan, would not have to be paid, such as services performed by a family member;
- chiropractic spinal manipulations under anesthesia;
- cosmetic surgery except:
  - for a covered child's congenital anomalies;
  - for all stages of reconstruction on a non-diseased breast to make it equal in size to the reconstructed diseased breast following mastectomy;
  - for reconstructive breast surgery on the diseased breast necessary because of a mastectomy; and
  - when related to a disfiguring injury;
- court-ordered services or programs not judged medically necessary by the plan;
- custodial care solely to assist with normal daily activities (such as dressing, feeding and ambulation) or any other treatment that doesn't require the services of a registered nurse or licensed practical nurse;
- dental charges, except for natural teeth injured in an accident while covered by the plan (this treatment must be within one year of the accident);
- exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, licensing, certification, registration, sports or recreational activities;

- experimental or investigational services, supplies or settings determined to be experimental or investigational (see the "Health Care Glossary" for further information);
- fertility services, such as:
  - any fees related to donors, donor sperm and banking services;
  - drugs to treat infertility—for example, menotropins such as Pergonal;
  - procedures to reverse voluntary sterilization;
  - fertility services for covered children;
  - sexual dysfunction treatment or related diagnostic testing;
  - some assisted reproductive technology (ART) methods;
  - surrogate parenting fees; and
  - voluntary removal of birth control devices implanted under the skin—for example, Norplant;
- foot care considered routine, such as:
  - arch supports or orthotics unless needed for diabetes or other covered conditions;
  - corrective orthopedic shoes;
  - hygienic care;
  - removal of corns or calluses; and
  - treatment for flat feet;
- home health care services involving:
  - custodial care, except by home health aides as ordered in the approved plan of treatment;
  - housecleaning;
  - services or supplies not included in the written plan of treatment;
  - services provided by a person who resides in your home or is a family member; and
  - travel costs or transportation services;
- hospice care services involving:
  - any services provided by members of the patient's family;
  - financial or legal counseling, such as estate planning or the drafting of a will;
  - funeral arrangements;

  - homemaker, caretaker or other services not solely related to the patient, such as:
    - housecleaning or upkeep;
    - sitter or companion services for either the plan member who is ill or for other dependents; and
    - transportation.
- hospital inpatient convalescent, custodial or domiciliary care;
- hospitalization solely for diagnostic purposes when not medically necessary;
- injuries to teeth caused by biting or chewing;
- injuries sustained:
  - by an intentional overdose of a legal prescription, over-the-counter drug, illegal drug or other chemical substance;
  - while engaged in any activity that results in a felony conviction; or
  - while performing any acts of violence or physical force;
- mental health services involving:
  - biofeedback;
  - custodial care;
  - specialty programs for mental health therapy not provided by KingCare[SM]; and
  - treatment of sexual disorders;
- non-approved drugs and substances (those the FDA has not approved for general use and has labeled "Caution—Limited by federal law to investigational use");
- services and supplies not medically necessary to treat illness or injury, except for newborns and unless otherwise specified;
- services of a provider related to you by blood, marriage, adoption or legal dependency;
- services or expenses related to schools or other non-medical facilities that primarily supply educational, vocational, custodial and/or rehabilitative support training or similar services;
- non-medical sexual dysfunction, treatment and prescriptions;
- skilled nursing facility services involving:
  - custodial care;
  - services or supplies not included in your physician's written plan of treatment;
  - services provided by a person who resides in your home or is a family member;

  - skilled nursing facility confinement for developmental disability or primarily domiciliary, convalescent or custodial care; and
  - travel costs;
- smoking cessation-related inpatient services, books or tapes, or vitamins, minerals or other supplements;
- third-party required treatment or evaluations such as those for school, employment, flight clearance, summer camp, insurance or court;
- transgender services not specified in "Covered Expenses," including:
  - abdominoplasty;
  - blepharoplasty;
  - breast augmentation;
  - brow lift;
  - calf implants;
  - cheek/malar implants;
  - chin/nose implants;
  - collagen injections;
  - drugs for hair loss or growth;
  - face-lift;
  - facial bone reduction;
  - forehead lift;
  - hair removal;
  - hair transplantation;
  - lip reduction;
  - liposuction;
  - mastopexy;
  - neck tightening;
  - pectoral implants;
  - reduction thyroid chondroplasty;
  - rhinoplasty;
  - suction-assisted lipoplasty of the waist;
  - voice modification surgery;
  - voice therapy/lessons;

- transplant costs and services involving:
  - donor costs for a transplant not covered under the plan, or for a recipient who isn't a plan member (however, complications and unforeseen effects from a plan member's organ or bone marrow donation are covered);
  - donor costs for which benefits are available under other group coverage;
  - non-human or mechanical organs unless deemed non-experimental and non-investigational by the plan; and
  - the cost of food for the transplant recipient and the recipient's companion;
- treatment (inpatient or outpatient) of chronic mental health conditions such as mental retardation, mental deficiency or forms of senile deterioration resulting from service in the armed forces, declared or undeclared war, or voluntary participation in a riot, insurrection or act of terrorism;
- vision tests unless due to illness or injury. The plan also doesn't cover:
  - contact lenses (except for cataract surgery);
  - eyeglasses or their fittings;
  - orthoptics;
  - radial keratotomy or similar surgery for treating myopia; and
  - visual analysis, therapy or training.

Filing a Claim

If you receive care from Regence network providers, they submit claims for you.

If you receive care from an out-of-network provider, your provider may submit a claim for you. However, if your out-of-network provider doesn't submit a claim for you, it is your responsibility to pay the provider in full and submit a claim to Regence for reimbursement of Regence's portion of the claim. Claim forms are available from Regence at the KingCare[SM] member Web site: www.regence.com.

When submitting any claim, you need to include your itemized bill. It should show:

- patient's name;
- provider's tax ID number;
- diagnosis or ICD-9 code;
- date of service/supply; and
- itemized charges from the provider for the services/supplies received.

You also need to provide:

- your name (if you're not the patient);
- your unique identifier number on your ID card

For prompt payment, submit all claims as soon as possible to:

Regence BlueShield
P.O. Box 30271
Salt Lake City, UT 84130-0271

Generally, KingCare[SM] will not pay a claim submitted more than 12 months after the date of service or the date expenses were incurred. If you can't meet the 12-month deadline because of circumstances beyond your control, such as being legally incapacitated, the claim will be considered for payment when accompanied by a written explanation of the circumstances. However, to be considered, the claim must have been submitted by you or Regence within the 12-month period for submitting a claim.

How Regence Reviews Preauthorization Requests and Claims

Regence will review your claim and notify you or your provider in writing within the following time frames:

- **within 72 hours for urgent preauthorization requests.** Preauthorization requests for urgent claims are those where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. You'll be notified of the preauthorization claim review decision by phone and later by a written notice.
- **within 15 days for pre-service preauthorization requests for (within 30 days if an extension is filed).** Preauthorization requests for pre-service claims are those where KingCare[SM] requires you to obtain approval of the benefit before receiving the care. KingCare[SM] may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **within 15 days for concurrent preauthorization requests.** Preauthorization requests for concurrent claims are those for continuation of services previously approved by the claims administrator as an ongoing course of treatment or to be provided over a certain period. Additional information should be requested in writing. KingCare[SM] may pend for 45 days to allow time for additional information to be received. Written notice of the determination must be given within 15 days of receipt of the additional information.
- **within 24 hours for urgent concurrent preauthorization requests.** Preauthorization requests for urgent concurrent claims are those for continuation of services previously approved by the claims administrator as an ongoing course of treatment or to be provided over a certain period. KingCare[SM] may pend for 48 hours to allow time for additional information to be received. Additional information is requested by phone. Verbal notice of the determination must be given the same day as the decision. Written notice must be sent within three calendar days from the verbal notice.

- **within 30 days for post-service claims unless an extension is required.** Post-service claims are claims that aren't urgent, pre-service or concurrent. KingCare[SM] may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information. Claims may be denied if information is not provided within 45 days.

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

If Regence Approves the Claim

Payment for claims for network providers will be made directly to the provider. If you see an out-of-network provider and there is no indication the bill has been fully paid, payment for covered services is made on a co-payee check jointly issued to you and the provider. If the bill indicates full payment has been made to the provider, payment for covered services may be made directly to you.

Reimbursement for out-of-network providers is for the maximum allowable fees paid by KingCare[SM].

If Regence Denies the Claim

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that were reviewed in making the determination. (For information about appeals, see "KingCare[SM]" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

Using Your Prescription Drug Plan

Prescription drug services for KingCare[SM] members are provided by Express Scripts, a pharmacy benefit manager that isn't affiliated with Regence. Express Scripts contracts with pharmacies that participate in its nationwide network. The network includes all major chain pharmacies and most independent pharmacies, as well as a mail-order service, which have agreed to dispense covered prescription drugs to plan members at a discounted cost and not to bill plan members for any amounts over the copays.

WHO'S IN THE EXPRESS SCRIPTS NETWORK?

For a list of participating network pharmacies, contact Express Scripts.

Express Scripts issues a separate prescription card to KingCare[SM] members to use when filling prescriptions at network pharmacies or through the Express Scripts mail-order service. If you don't show your prescription card, the network pharmacy cannot confirm that you're covered through Express Scripts. In this case, you'll need to pay the pharmacy in full and submit a claim to Express Scripts for reimbursement.

You may receive up to a 30-day supply from a retail network pharmacy. You may receive a 30-day, 60-day or 90-day supply per prescription or refill through the mail-order service. If you use the mail-order service, you pay the 90-day copay even if your prescription is written for less than a 90-day supply.

Accessing Care

You may receive network benefits or out-of-network benefits, but the level of coverage depends on the pharmacy you use.

Retail Pharmacy Purchases

To fill a prescription at a network pharmacy and receive network benefits:

- you must choose an Express Scripts network pharmacy;
- show your Express Scripts prescription card to the network pharmacist each time you fill or refill a prescription (your Regence medical card isn't valid when you purchase prescription drugs); and
- pay the copay for each covered new prescription or refill. There are no claim forms to submit because the network pharmacy bills the plan directly.

For certain prescription drugs and quantities, your physician will need to obtain preauthorization from Express Scripts.

If you fill a prescription at an out-of-network pharmacy, you must pay the cost of the prescription and submit a claim to Express Scripts for reimbursement. Express Scripts reimburses you at the rate it would pay a network pharmacy, less the appropriate copay. **Any amount in excess of this rate is your responsibility.**

Mail-Order Purchases

You may purchase maintenance drugs through the mail-order service. "Maintenance drugs" are drugs you must take on an ongoing basis. The first time you use the mail-order service, fill out the patient information questionnaire on the order form available from Express Scripts. This form also includes options for payment. You need to complete this questionnaire only once.

Each time you order a new prescription, you can either:

- send the order form and prescription, together with your payment, directly to the address on the form; or
- have your physician fax the prescription directly from his/her office or call Express Scripts directly.

Once you've submitted the order form, you may obtain refills through the Express Scripts Web site, mail in your refill slip or call Express Scripts.

All prescriptions are processed promptly and usually arrive within 14 days. If you don't receive your medicine within 14 days or if you have questions, contact Express Scripts customer service.

If you use the mail-order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply. There's no out-of-network mail-order service.

SPECIALTY PHARMACY/ACCREDO

If you take specialty injectable/biotech prescription drugs, you may fill your specialty prescriptions at a local retail pharmacy one time only. For all subsequent prescriptions of your medication, you'll be directed to fill your prescriptions through Accredo, Express Scripts' specialty pharmacy. After your first retail fill, Accredo will send you a letter that details how to have your prescription transferred to the specialty pharmacy. If you want to contact Accredo directly to receive your supply of specialty medication(s), call Express Scripts.

Express Scripts is closed Sundays and holidays, including New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas.

A patient care coordinator will contact your doctor and work with you to schedule a delivery time for your medication.

Coverage While Traveling Outside the U.S.

If you will be traveling outside the United States, you can notify Express Scripts in advance of your travel and obtain up to a three-month supply of your prescription drugs from a network pharmacy at the regular copay rate. Express Scripts will allow you and your covered dependents to obtain an advance three-month supply of medications for foreign travel up to two times a year per person.

If you will be traveling abroad for longer than three months, be prepared to purchase your prescription drugs at the retail rate in those other countries after your supply runs out. When you return to the United States, you will need to submit a claim for reimbursement of prescription drug purchases you made in those other countries. Your purchase of prescription drugs in other countries will be treated as an out-of-network expense and will be reimbursed at the out-of-network rate. For purposes of claim reimbursement, Puerto Rico, Guam and the U.S. Virgin Islands are not considered foreign countries, but cruise ships are.

For more information about filing a claim for prescription drugs purchased outside the U.S., contact Express Scripts before you travel.

Coverage during a Natural Disaster

When a natural disaster occurs, prescriptions drugs may be lost or destroyed, and home delivery may not be feasible. Under certain circumstances resulting from a natural disaster, Express Scripts may choose to allow members living in affected areas to obtain prescription drugs ahead of the regular refill schedule. For more information about obtaining prescriptions during a natural disaster, contact Express Scripts.

Formulary

Your copay for a particular prescription is based on a list of drugs called a formulary, which sets the copay for that particular prescription based on its inclusion or exclusion in the formulary. For a copy of the formulary, including formulary alternatives, contact Express Scripts.

Preauthorization

Express Scripts doesn't determine the maximum number of refills or period when a prescription is valid because these limitations are mandated by federal and state laws regulating pharmacy practices. To promote proper use of medications, preauthorization and quantity-level limits have been implemented for certain prescriptions under your KingCare[SM] pharmacy benefit.

You or your prescribing physician can find out if preauthorization is required by contacting Express Scripts before you have a prescription filled. For you and your physician's convenience, Express Scripts customer service assistance is available 24 hours a day, seven days a week at 1-800-332-2213. Otherwise, your pharmacist or the Express Scripts mail-order service will advise you of the preauthorization procedures required to fill the prescription.

Express Scripts routinely reviews prescribing guidelines to ensure that drugs are clinically appropriate, and may limit the quantities of certain drugs to ensure proper utilization. The list of drugs requiring preauthorization is subject to change. (The most current list of these drugs is available at the Express Scripts Web site: www.express-scripts.com.)

To preauthorize a prescription, your prescribing physician or his/her representative must initiate the process with a phone call to Express Scripts.

During the course of the review process, your eligibility will be confirmed and your prescription records checked to see if the prescription meets the established criteria.

Preauthorization requests are evaluated using criteria approved by KingCare[SM]. The request is then approved, denied or held for further information. If more information is required, Express Scripts will notify the requestor. Once the information is provided by your physician, your request will be approved or denied.

If the request is approved, Express Scripts will notify your physician and immediately update its database so you can fill the prescription.

If the request is denied, an Express Scripts clinical pharmacist will verify that the denial is valid according to plan criteria. Express Scripts will then notify:

- your physician verbally if the request was received by phone call; or
- you and your physician in writing if the request was received by mail.

When you receive a written denial, you may appeal that decision.

What's Covered and What's Not

Covered Expenses

Your King County prescription benefit covers:

- contraceptives (including oral, injectable, vaginal, topical and implantable);
- DESI drugs;
- emergency allergic reaction kits;
- emergency contraceptives;

- erectile dysfunction drugs, if used to treat impotency or penile dysfunction and preauthorized;
- flu vaccinations performed at pharmacies contracted with Express Scripts;
- glucagon emergency kit;
- injectable prescription drugs purchased at a retail pharmacy or through mail-order as a specialty drug (for some, preauthorization may be required; some injectables may be covered under medical services for a patient at a hospital);
- insulin and diabetic supplies, including:
  - alcohol swabs;
  - blood glucose testing strips;
  - injection devices (such as Novopen);
  - insulin administered by pen/cartridge or other special injection devices;
  - insulin needles and syringes;
  - insulin/pre-drawn syringes;
  - keytone testing strips;
  - lancets;
  - lancet devices;
  - monitors; and
  - urine glucose testing strips;
- legend drugs;
- ostomy supplies;
- medically necessary vitamins;
- shingles (zoster) vaccination at age 55 and older, performed at pharmacies contracted with Express Scripts;
- smoking cessation drugs, inhalers and nasal sprays requiring a prescription (claims for non-prescription nicotine patches, lozenges and gum are covered at 100% through Regence; and
- topical smoking cessation patches whether prescription or over-the-counter.

Expenses Not Covered

The following items are not covered by your King County prescription benefit:

- anorexiants/weight-loss medications;
- any over-the-counter medication unless otherwise noted;
- blood products;
- compound drugs of which at least one ingredient is not a covered prescription drug;

- cosmetic/hair loss medications;
- experimental medications that have not been approved by the FDA;
- infertility medications;
- therapeutic devices or appliances, including hypodermic needles, syringes (except those used for insulin and in the course of administering medical treatment), support garments and other non-medical substances regardless of intended use; and
- vitamins (except prenatal).

In addition to the exclusions or limits described in other sections of this guide, KingCare[SM] doesn't cover:

- charges that exceed the amounts Express Scripts pays its network pharmacies;
- drugs for a covered child's maternity care;
- infertility drugs, including Viagra (unless preauthorized);
- non-approved drugs and substances (those the FDA hasn't approved for general use and has labeled "Caution—Limited by federal law to investigational use"); and
- treatment of sexual dysfunction regardless of cause, including, but not limited to devices, implants, surgical procedures, and medications.

Managing Your Medications

Through a program called Medication Therapy Management Services, you may receive personal consultation on managing the interactions and potential complications of the multiple medications you're taking. Without additional cost to you, you may ask certified pharmacists to:

- review your entire list of medications, including prescription, herbal and over-the-counter medications, to make sure you're not taking medications that conflict with each other;
- answer your questions about correct dosage and frequency of dosage;
- answer your questions about risks and side effects from multiple prescriptions (certified pharmacists make one follow-up call to make sure you're not experiencing complications);
- find a less expensive medication covered under KingCare[SM]; and
- answer questions about over-the-counter medications.

Filing a Claim

When you go to a network pharmacy, there's no claim to file. However, if you fill a prescription at an out-of-network pharmacy, you're responsible for paying the pharmacy in full and submitting a claim to Express Scripts, which will reimburse you at the negotiated rate within its network. To obtain a claim form, contact Express Scripts. For the group number to use when filing a claim, see *Contact Information*.

When submitting a pharmacy claim, you need to include a completed claim form, together with the original prescription receipt, containing the following information:

- patient's name;
- NCPDP number (pharmacy's number) if listed on label;
- prescription number;
- date filled;
- dollar amount;
- quantity;
- days' supply; and
- NDC number (drug code).

After your claim is processed, you'll receive written notice describing the approval (amount submitted, amount covered/allowed and amount of reimbursement) or the reason for denial. Payment for covered prescriptions is made directly to you. Reimbursement typically takes about 14 days.

For prompt payment, submit all claims as soon as possible to:

Express Scripts, Inc.
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872.

Generally, Express Scripts will not pay a claim submitted more than 12 months after the date of service or the date expenses were incurred. If you can't meet the 12-month deadline because of circumstances beyond your control, such as being legally incapacitated, submit the claim to King County along with a written explanation of the circumstances. The county will determine whether your claim should be considered for payment.

If your claim is denied, you may appeal. (For information about appeals, see "KingCare[SM]" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

SmartCare Connect (Group Health)

To make the most of the benefits available under SmartCare Connect (administered by Group Health), you need to understand how the plan works.

Accessing Care

When you're enrolled in Group Health, you'll receive benefits if you see your primary care physician (PCP) or another provider within the network. You'll pay a copay when you receive care. After the copay, Group Health pays 100% for most covered services and handles all forms and paperwork for you.

If you see a provider who isn't part of the network, you'll receive benefits **only** if:

- you need emergency care; or
- your network provider refers you to an out-of-network provider.

Medical and prescription drug benefits under Group Health are administered by Group Health. You receive a single ID card from Group Health for both your medical and prescription drug coverage. For your group number, see *Contact Information*.

Network Providers

Network providers may be either staff members of Group Health or contracted providers. Services of contracted providers must be preauthorized.

All providers who make up the network are carefully screened by Group Health. Physicians and other health care professionals must complete a detailed application to be considered for the network. The application covers education, status of board certification, and malpractice and state sanction histories. For a list of network providers, contact Group Health.

Out-of-Area Coverage

Group Health doesn't provide out-of-area benefits except for emergency care. If you or a covered dependent is away from home, you may be able to access urgent or emergency care at network benefit levels in health maintenance organizations (HMOs) associated with Group Health. You or your covered dependent can use the Kaiser Permanente network for urgent or emergency care while traveling. For out-of-area emergency care, contact 1-888-901-4636 or 1-888-457-9516.

Your Primary Care Physician (PCP)

Your primary care physician (PCP) is your personal physician and the coordinator of all your medical care. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your PCP can arrange it.

You're strongly encouraged to select a PCP from the Group Health network provider directory when you enroll. Each covered dependent may have a different PCP. The provider directory is updated periodically. For current information about providers, contact Group Health.

IMPORTANT!

Continuity of care is important and easier to achieve if you establish a long-term relationship with your PCP. However, if you find it necessary to change your PCP, call Group Health.

Specialists

Your PCP can provide or coordinate your medical care, including referring you to specialists. In most cases, your PCP will refer you to a network specialist. If you wish, you may make appointments directly with any Group Health staff specialist without a referral from your PCP. However, referrals are required to see contracted specialists. (You can tell the difference between a Group Health staff specialist and a contracted specialist because only Group Health staff specialists practice in Group Health facilities.)

When you're referred to any network specialist, be sure to get a copy of the referral form from your PCP and take it to the specialist. To allow your PCP to coordinate your care most effectively, check back with him/her after a specific time or number of specialist visits. If you have a complex or chronic medical condition, you may obtain a standing specialist referral.

For medically necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for these services, you may see a participating general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advanced registered nurse practitioner who is contracted by Group Health to provide women's health care services directly, without a referral from your PCP. If your women's health care provider diagnoses a condition that requires a referral to other specialists or hospitalization, you or your provider must obtain preauthorization.

If you see an out-of-network provider without a referral, benefits won't be payable.

If You Live Outside the Network Service Area

If you retire and continue to live in Washington—even if you move out of the Group Health service area—you may continue to be covered by Group Health under the following conditions:

- all services, except emergencies, must be provided by a Group Health provider or contracted provider. Services of a contracted provider must be preauthorized.
- emergency services are available outside the Group Health network, but they're subject to the increased emergency room payments. Emergency admissions must be reported within 24 hours or as soon as reasonably possible (phone numbers for reporting emergency admission to a hospital are on the back of your Group Health ID card).

- if you live in an area served by Kaiser Permanente, you won't be able to access care through the Kaiser network. Group Health's reciprocity agreement with Kaiser covers members only during short-term travel.

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive medical coverage under your Group Health insurance for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations.

Paying for Your Care

Medical and prescription drug benefits under Group Health are administered by Group Health. You receive a single ID card from Group Health for both your medical and prescription drug coverage. Here are important definitions of common terms related to paying for your care.

Copay

You pay copays for medical care and prescription drugs at the time you receive service.

Coinsurance

"Coinsurance" is the amount you and Group Health share toward covered expenses.

Annual Out-of-Pocket Maximum

The "annual out-of-pocket maximum" is the most you pay in copays for covered medical expenses each year. Once you reach the annual out-of-pocket maximum, Group Health pays 100% for most covered expenses for the rest of that year. If you have three or more covered dependents (including yourself), each dependent's covered expenses accumulate toward the family out-of-pocket maximum.

The following expenses don't apply to the annual out-of-pocket maximum:

- expenses not covered under your Group Health plan;
- health education;
- hearing aids;
- prescription drug copays.

Lifetime Maximum Benefit

There's no lifetime maximum benefit under Group Health.

Other Features of Group Health

It's important to understand other features of Group Health, such as disease management and second opinions. Having a better understanding of how the plan works will enable you to use the plan wisely and take advantage of all the benefits that the plan has to offer.

Health Care Management

In addition to your health benefits, Group Health offers several other features and services that you can use to manage your health and the health of your family.

Consulting Nurse Line

You can talk to a registered nurse 24 hours a day, seven days a week, to get information on a variety of health and wellness topics, including advice on when to seek emergency care.

You can speak with a registered nurse by calling 1-800-297-6877.

Group Health CareNow

CareNow is an online diagnosis and treatment service for common medical conditions. If you are age 18 or over, you can pay a flat fee of $25, fill out an online questionnaire, and receive your diagnosis within an hour between 9 a.m.-7 p.m. PT. If necessary, CareNew can phone in a prescription to a network pharmacy of your choosing.

Scheduled Phone Visit

Save yourself a trip to the doctor's office! Log into www.ghc.org or call your provider's office to schedule a phone visit. Your provider will call you at the specified time to discuss your health concerns over the phone.

Online Tools and Secure Email Portal

Group Health makes it easy to access your medical history and communicate with your providers. Sign into www.ghc.org to:

- manage your appointments and medications;
- exchange e-mail messages with your health care providers;
- view after-visit summaries, lab results and more.

Walk-In CareClinics

Adults and children age two or older can receive care for minor injuries and illnesses at one of three Bartell Drug locations in Ballard, Crossroads and University Village. CareClinics are staffed with Group Health board-certified physician assistants and nurse practitioners.

Urgent Care Centers

For non-life-threatening conditions that require immediate care, visit one of five Group Health clinics in the Puget Sound area and 18 urgent care centers in the Spokane area. Use the provider directory on www.ghc.org to locate an urgent care clinic near you.

Living Well with Chronic Diseases

Through this service, you can:

- learn skills for managing your chronic conditions such as arthritis, stroke, heart disease, chronic pain and diabetes;
- manage pain and medications;
- get help with emotional challenges;
- design an exercise program;
- manage stress;
- improve your quality of life; and
- get help working with your health care team.

You can access this service by logging on to MyGroupHealth at www.ghc.org or by calling 1-888-901-4636.

Clinical Trials

Group Health is affiliated with the Seattle Cancer Care Alliance. In collaboration with Seattle Cancer Center Alliance, Fred Hutchinson Cancer Research Center, Swedish Medical Center and national cooperative groups, they conduct oncology clinical trials to identify new and innovative ways to treat cancer.

(For additional services available to members, visit www.ghc.org.)

Second Opinions

On occasion, you may want a second opinion from another physician regarding a medical diagnosis or treatment plan. To receive benefits, you must obtain the second opinion from a network provider.

Knowing What's Covered and What's Not

The following are guidelines for what is considered a "covered expense."

Covered Expenses

Only medically necessary services, supplies and prescription drugs are covered.

Alternative Care

Covered alternative care services, when medically necessary, include:

- acupuncture (certain limits apply);
- home births for low-risk pregnancies (see any Group Health network midwife for covered prenatal and home birth services);

- massage therapy, as part of a formal rehabilitation program; and
- naturopathy (certain limits apply).

You can self-refer for acupuncture and naturopathy care, but referral by a PCP is required for home births and massage therapy. You must use a network provider for these services.

Ambulance Services

Group Health covers ambulance services if:

- ordered or approved by a network provider;
- other transportation would endanger your health; and
- the transportation isn't for personal or convenience reasons.

Applied Behavioral Analysis Therapy for Autism-spectrum Disorders

Applied behavioral analysis (ABA) therapy involves the design, implementation and evaluation of environmental modifications to produce socially significant improvement in human behavior. It also involves the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Eligible ABA therapy providers include:

- licensed and credentialed speech therapists, occupational therapists, psychologists, pediatricians, neurologists, psychiatrists, mental health counselors and social workers who are board-certified behavior analysts; and
- board-certified behavior analysts and therapy assistants working under the supervision of licensed, credentialed providers.

To be eligible for this coverage, the member must:

- have a referral for ABA therapy from a licensed health, mental health or allied health provider, such as a physician, psychologist or speech-language pathologist;
- have received a diagnosis of an autism-spectrum disorder by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism; and
- must be able to provide documented diagnostic assessments, individualized treatment plans and progress evaluations.

Coverage is provided at any age for the following conditions:

- autistic disorder, as defined by the *International Classification of Diseases*, *Ninth Revision;*
- childhood disintegrative disorder;
- Asperger's disorder;
- Rett's disorder and pervasive development disorder not otherwise specified (atypical autism); and
- pervasive developmental disorder.

Chemical Dependency Treatment

Chemical dependency is a physiological and/or psychological dependency on a controlled substance and/or alcohol which substantially impairs or endangers your health, or substantially disrupts your ability to function socially or to work.

Your PCP can arrange chemical dependency treatment, or for outpatient care, you may call Group Health Behavioral Health. For additional counseling and referral services, you may also call the Making Life Easier Program.

Treatment may include the following inpatient or outpatient services:

- covered prescription drugs and medicines;
- diagnostic evaluation and education; and
- organized individual and group counseling.

Detoxification services are covered as any other medical condition.

Diabetes Care Training and Supplies

Diabetes care training includes diet counseling, enrollment in diabetes registry and a wide variety of education materials.

Group Health covers the following supplies under either the prescription drug or durable medical equipment benefit:

- blood glucose monitoring reagents;
- diabetic monitoring equipment;
- external insulin pumps;
- insulin syringes;
- lancets; and
- urine testing reagents.

Durable Medical Equipment, Devices and Supplies

Group Health covers durable medical equipment if it:

- is designed for prolonged use;
- has a specific therapeutic purpose in treating an illness or injury;
- is prescribed by your Group Health physician and is part of the Group Health formulary; and
- is primarily and customarily used only for medical purposes.

For durable medical equipment, you pay a coinsurance amount rather than a copay amount.

Covered items include:

- artificial limbs or eyes (including implant lenses prescribed by a network provider and required as the result of cataract surgery or to replace a missing portion of the eye);

- diabetic equipment for home testing and insulin administration (excluding batteries) not covered under the prescription benefit;
- external breast prosthesis and bra following mastectomy (1 external breast prosthesis per diseased breast every 2 years and 2 post-mastectomy bras every 6 months—up to 4 in any consecutive 12 months);
- non-prosthetic orthopedic appliances attached to an impaired body segment. These appliances must protect the body segment or aid in restoring or improving its function;
- orthopedic appliances;
- ostomy supplies;
- oxygen and equipment for its administration;
- prosthetic devices;
- purchase of nasal CPAP devices and initial purchase of associated supplies (Group Health provides a referral; you must rent the device for two months before it may be purchased; you pay coinsurance on both the rental and purchase cost);
- rental or purchase (decided by Group Health) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price); and
- splints, crutches, trusses or braces.

Emergency Room Care

Emergency room care is for medical conditions that threaten loss of life or limb or may cause serious harm to the patient's health if not treated immediately. You don't need a referral from your PCP before you receive emergency room care. Examples of conditions that might require emergency room care include:

- an apparent heart attack (chest pain, sweating, nausea);
- convulsions;
- major burns;
- severe breathing problems;
- unconsciousness or confusion, especially after a head injury; and
- uncontrollable bleeding.

If you need emergency room care, follow these steps:

- call 911 or go to the nearest hospital emergency room immediately. In cases when you can choose an emergency location, go to the Eastside Hospital in Redmond—this will allow Group Health to coordinate your care efficiently and perhaps reduce your expenses.
- when you arrive, show your Group Health ID card.
- if you're admitted to an out-of-network facility, you must call 1-888-457-9516 within 24 hours; otherwise, you may be responsible for all costs incurred before you call. If

you're unable to call, ask a friend, relative or hospital staff person to call for you. Group Health's phone number is printed on the back of your ID card.

- if you're admitted to a non-Group Health facility, you must notify Group Health within 24 hours. You may be required to transfer your care to a network provider and/or Group Health facility. If you refuse to transfer to a Group Health facility, all further costs incurred during the hospitalization will be your responsibility.

In general, follow-up care that is the direct result of the emergency must be received through Group Health. Non-emergency use of an emergency facility isn't covered.

Family Planning

Group Health covers the following family planning expenses:

- family planning counseling;
- services to insert intrauterine birth control devices (IUDs);
- sterilization procedures; and
- voluntary termination of pregnancy (abortion).

Birth control drugs are covered under the prescription drug benefit.

Growth Hormones

Group Health covers growth hormones without a waiting period.

Hearing Aids

Group Health covers hearing examinations, hearing aids and fittings.

Home Health Care

Group Health covers home health care if the patient is unable to leave home due to health problems or illness and the care is necessary because of a medically predictable, recurring need. Unwillingness to travel and/or arrange for transportation doesn't constitute an inability to leave home. If you have an approved plan of treatment and referral from a network provider, covered expenses include:

- medical social worker and limited home health aide services;
- nursing care;
- occupational therapy;
- physical therapy;
- respiratory therapy; and
- restorative speech therapy.

Hospice Care

Hospice care is a coordinated program of supportive care for a dying person provided by a team of professionals and volunteers. The team may include a physician, nurse or medical social worker; physical, speech, occupational or respiratory therapist; or home health aide under the supervision of a registered nurse.

Group Health covers hospice services if:

- a network provider determines that the patient's illness is terminal with a life expectancy of six months or less and it can be appropriately managed in the home or hospice facility;
- the patient has chosen comforting and supportive services rather than treatment aimed at curing the terminal illness;
- the patient has elected in writing to receive hospice care through the Group Health-approved hospice program; and
- the patient has a primary care person who will be responsible for the patient's home care.

One period of continuous home care hospice service is covered. A continuous home care period is skilled nursing care provided in the home 24 hours a day during a period of crisis to maintain a terminally ill patient at home. A network provider must determine that the patient would otherwise require hospitalization.

Continuous respite care may be covered for up to five days per occurrence of hospice care. Respite care must be given in the most appropriate setting as determined by your network provider.

Other covered hospice services may include:

- counseling services for the patient and the primary caregiver(s);
- drugs and biologicals used primarily for the relief of pain and symptom management;
- medical appliances and supplies primarily for the relief of pain and symptom management; and
- bereavement counseling services for the family.

Hospital Care

Group health covers the following hospital care expenses:

- drugs and medications administered during confinement;
- hospital services;
- room and board; and
- special duty nursing.

If you or your covered dependent is hospitalized and your medical coverage ends, the plan continues to provide coverage until:

- it is no longer medically necessary for you to be an inpatient at the facility, according to GHC clinical criteria;
- the remaining benefits for the hospitalization are exhausted, regardless of whether a new calendar year begins;
- you become covered under another agreement with a group health plan that provides benefits for the hospitalization;

- you become enrolled under an agreement with another health plan carrier that would provide benefits for the hospitalization if you weren't covered by this plan; or
- you become eligible for Medicare.

Injury to teeth

The services of a licensed dentist are covered for the repair of accidental injury to sound, natural teeth. Injures caused by biting or chewing are not covered. All services must be provided within 12 months of the date of injury. The treatment period for a child under age 14 will be expanded to allow the child to reach a point of development where treatment will be effective; however, the child will only be eligible to receive the treatment if he/she was covered at the time of the accident and remains continuously covered through the time period in which the treatment is provided.

Inpatient Care Alternatives

Information about inpatient care alternatives is available under "Home Health Care" on page 80 and "Skilled Nursing Facility" on page 86.

Lab, X-ray and Other Diagnostic Testing

Group Health covers diagnostic X-ray, nuclear medicine, ultrasound and laboratory services. For plan benefits, see "Group Health Benefits at a Glance." For more information on routine diagnostic testing such as a mammogram, see "Preventive Care."

Maternity Care

Group Health covers maternity care if provided by a:

- physician; or
- midwife licensed by the State of Washington.

Covered maternity care includes:

- prenatal care (outpatient copay waived unless specialized treatment is required);
- complications of pregnancy or delivery;
- hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies;
- postpartum care (outpatient copay waived unless specialized treatment is required);
- pregnancy care;
- related genetic counseling when medically necessary for prenatal diagnosis of an unborn child's congenital disorders; and
- screening and diagnostic procedures during pregnancy.

HOSPITAL STAYS AND FEDERAL LAW

Group medical plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally doesn't prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and insurers may not require a provider to obtain authorization for prescribing a stay that doesn't exceed 48 hours or 96 hours, as applicable.

You don't need to preauthorize the length of stay unless it exceeds the 48- or 96-hour rule.

Mental Health Care

Group Health covers inpatient and outpatient mental health services, which are covered at the same copay rates as other medical care and are applied against your annual out-of-pocket maximum. These services, which place priority on restoring social and occupational functioning, include:

- consultations;
- crisis intervention;
- evaluation;
- intermittent care;
- managed psychotherapy; and
- psychological testing.

Your PCP can arrange for mental health services, or you may contact Group Health Behavioral Health directly. Counseling and referral services are also available through the Making Life Easier Program. Group Health also covers services authorized by Group Health's medical director which can be expected to improve or stabilize a condition.

Neurodevelopmental Therapy

Group Health covers neurodevelopmental therapy services, which include:

- hospital care;
- maintenance of the patient when his or her condition would significantly worsen without such services;
- occupational, speech and physical therapy (if ordered and periodically reviewed by a physician);
- physician services; and
- services to restore and improve function.

Newborn Care

Group Health covers newborns under the mother's health plan for the first three weeks, as required by Washington state law. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled using benefit enrollment forms.

Phenylketonuria (PKU) Formula

Group Health covers the medical dietary formula that treats PKU.

Physician and Other Medical/Surgical Services

Group Health covers other medical and surgical services, including:

- allergy serum;
- bariatric surgery and related hospitalizations when Group Health criteria are met;
- blood and blood derivatives and their administration;
- circumcision;
- general anesthesia services and related facility charges for dental procedures for patients who are under age seven, who are physically or developmentally disabled or who have a medical condition where the patient's health would be put at risk if the dental procedure were performed in the dentist's office. These services must be authorized in advance by Group Health and performed at a Group Health hospital or ambulatory surgery facility;
- non-experimental implants limited to cardiac devices, artificial joints and intraocular lenses;
- outpatient diagnostic radiology and lab services;
- outpatient radiation therapy and chemotherapy;
- outpatient surgical services;
- outpatient total parenteral nutrition therapy;
- procedures performed by a network provider or oral surgeon for reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth; and incision of salivary glands and ducts;
- services of a podiatrist;
- sterilization procedures; and
- treatment of growth disorders by growth hormones.

Prescription Drugs

Benefits are provided for legend drugs and other covered items, including insulin, injectables and contraceptive drugs and devices when you use a network pharmacy or the mail-order service, including off-label use of FDA-approved drugs. To be covered, prescriptions must be:

- prescribed by a network provider for covered conditions; and
- filled through a network pharmacy or the mail-order service.

To fill your prescription through a network pharmacy, show the pharmacist your Group Health ID card. For mail-order prescriptions, your provider will first prescribe a 30-day "trial" supply, which you'll fill through a network pharmacy. If the trial supply is effective, you can order a 90-day supply by contacting the mail-order service through the Group Health Web site. Your prescription will be mailed to your home.

If you need a refill, check the label on the prescription container; some may be refilled without consulting your physician. The number of refills is indicated on the label. If you need your physician's approval to reorder your medication, call your pharmacy or the mail-order service at least two weeks before you run out of medication. The pharmacy/mail-order service will need time to order your medicine and contact your physician for approval.

Generic drugs are used whenever available. Brand-name drugs are used if there is no generic equivalent, in which case you pay the generic copay. However, if a generic is available for a brand-name drug and you choose to purchase the brand-name drug without a medical reason for its use, or if you choose to purchase a different brand-name or generic drug than your provider prescribed, you pay the additional amount above the generic cost.

Preventive Care

Group Health covers the following preventive care services:

- most immunizations and vaccinations for covered adults and children, including the one-time zoster (shingles) vaccine at age 55 or older and annual flu shots (except nasal flu sprays and immunizations for travel);
- routine hearing exams (once in 12 consecutive months);
- routine mammograms (age and risk factor determine frequency);
- diagnostic screening for prostate cancer as recommended by a physician, registered nurse or physician assistant (annual exams are recommended at age 40 and older);
- colorectal diagnostic screening for colon cancer as recommended by a physician for individuals age 50 and older and for younger high-risk individuals;
- routine physicals for covered adults and children (age and risk factor determine frequency); and
- routine vision exams (once in 12 consecutive months).

Preventive care is provided according to the following schedule. The schedule is a guideline; benefits may be available more frequently depending on your health care needs. Before scheduling a routine physical, confirm with Group Health that your physical will be covered.

Age	Preventive Care
Birth to 1 year	Routine newborn care, plus 7 well-baby office exams
1–2 years	2 well-child exams
2–5 years	4 well-child exams, with 1 exam in each of these age groups: 2, 3, 4, 5
6–12 years	4 well-child exams, with 1 exam in each of these age groups: 6, 7–8, 9–10, 11–12
13–17 years	2 well-teen exams, with 1 exam for ages 13–15 and 1 exam for ages 15–17
18–19 years	1 well-adult exam
20–39 years	1 well-adult exam every 4-5 years
40–49 years	1 well-adult exam every 4-5 years
50 years and older	1 well-adult exam every 2 years

Radiation Therapy, Chemotherapy and Respiratory Therapy

Group Health covers radiation therapy, high-dose chemotherapy and stem cell support, and respiratory therapy services.

Reconstructive Services

Group Health covers reconstructive services to correct a congenital disease/anomaly or a medical condition (following an injury or incidental to surgery) that had a major effect on the patient's appearance (the reconstructive services must, in the opinion of a network provider, be reasonably expected to correct the condition).

Group Health covers the following services if the patient is receiving benefits for a mastectomy and elects breast reconstruction in connection with the mastectomy, as determined in consultation with the attending physician:

- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas;
- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same copay and coinsurance provisions as are other medical and surgical benefits.

Rehabilitative Services

Group Health covers inpatient and outpatient rehabilitative services only for physical, occupational and speech therapy to restore function after illness, injury or surgery. Rehabilitative services are covered only when Group Health determines that they're expected to result in significant, measurable improvement within 60 days.

Skilled Nursing Facility

Group Health covers skilled nursing facility services when the patient is referred by a network provider.

Smoking Cessation

Group Health covers the following, without an annual or lifetime limit:

- Quit For Life®, a smoking cessation program covered at 100%, offers a variety of support options and educational materials. For more information, go to the Group Health Quit For Life® website or call 1-800-462-5327).

You may enroll in the tobacco cessation program anytime. Group Health covers approved smoking cessation products, such as gum, patches or prescription medication, in full when prescribed as part of the tobacco cessation program and dispensed through Group Health's mail-order service. Otherwise, you may purchase the products from a Group Health pharmacy or a contracted community pharmacy and pay the prescription drug copay.

Spinal Manipulatiions

Group Health covers medically necessary manipulative therapy of the spine and extremities. You don't need a referral from your PCP before you see a network chiropractor or osteopath—you may self-refer. Associated X-rays are covered when provided at a Group Health radiology facility.

Temporomandibular Joint (TMJ) Disorders

Group Health covers the following services for treating temporomandibular joint (TMJ) disorders:

- medical and surgical services and related hospitalizations to treat TMJ disorders when medically necessary;
- orthognathic (jaw) surgery;
- radiology services; and
- TMJ specialist services, including the fitting and adjustment of splints.

TMJ appliances are covered under the orthopedic appliances benefit. (See "Durable Medical Equipment, Devices and Supplies" for more information.)

Additional benefits are available through the dental plan.

Transgender Surgical Services

Group Health covers medically necessary medical and surgical services related to gender reassignment, including hospital inpatient and outpatient services.

Transplants

Group Health covers professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care, as well as certain donor expenses, related to transplants.

You and your covered dependents aren't eligible for organ transplant benefits, except for transplant-related drugs, until the first day of the seventh month of continuous coverage under Group Health, regardless of whether the condition necessitating the transplant existed before coverage began (unless the patient was continuously covered under this plan since birth or he/she requires a transplant as the result of a condition that had a sudden unexpected onset after the patient's effective date of coverage).

The following transplants are covered:

- bone marrow;
- cornea;
- heart;
- heart-lung;
- intestinal/multivisceral;
- kidney;
- liver;
- lung (single or double);
- pancreas;
- kidney; and
- stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high-dose chemotherapy.

Transplant services must be received at a facility designated by Group Health and are limited to:

- evaluation testing to determine recipient candidacy;
- follow-up services for specialty visits, re-hospitalization and maintenance medication; and
- transplantation (limited to medications and costs for surgery and hospitalization related to the transplant).

Group Health covers the following donor expenses for a covered organ recipient:

- excision fees;
- matching tests;
- procurement center fees; and
- travel costs for a surgical team.

Urgent Care

Group Health covers treatment for conditions that aren't considered a medical emergency but may need immediate medical attention. Examples of urgent conditions include:

- ear infections;
- high fevers; and
- minor burns.

If you need urgent care during office hours, call your PCP's office for assistance. After office hours, call Group Health's Consulting Nurse Service at 1-800-297-6877. Depending on your situation, the consulting nurse may provide instructions over the phone for self-care, instruct you to make an appointment with your PCP for the next day or advise you to go to the nearest urgent care or emergency room.

Urgent care is covered the same as other care.

Vision Exams

Group Health covers routine vision exams only. The vision plan provides benefits for eye exams and for prescription lenses and frames.

Expenses Not Covered

Group Health doesn't cover:

- applied behavioral analysis therapy expense for autism-spectrum disorders involving:
  - baby sitting or doing household chores;
  - time spent under the care of any other professional;
  - travel time or care time;
  - home schooling in academics or other academic tutoring;
  - rehabilitative services (may be covered under the rehabilitative benefit); and
  - mental health services (may be covered under the mental health, substance abuse and alcoholism treatment benefit);
- artificial or mechanical hearts;
- chiropractic expense involving:
  - care performed on a non-acute, asymptomatic basis;
  - care primarily for your convenience;
  - office visits other than for the initial evaluation;
  - supportive care performed primarily to maintain the level of correction already achieved; and
  - other services that don't meet Group Health clinical criteria for being medically necessary;
- complications of non-covered surgical services;
- conditions resulting from service in the armed forces during a declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism;
- convalescent or custodial care;
- corrective appliances or artificial aids, including eyeglasses, contact lenses or services related to their fitting, except as described under "Hearing Aids";

- cosmetic services, including treatment of complications from cosmetic surgery that is elective or not covered;
- court-ordered services or programs not judged medically necessary by the network provider;
- dental care, oral surgery, and dental services and appliances, except as described under "Physician and Other Medical/Surgical Services";
- diabetic meals and some diabetes education materials;
- evaluations and surgical procedures to correct refractions not related to eye pathology;
- exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, licensing, certification, registration, sports, or recreational or school activities;
- experimental or investigational treatment;
- gambling addiction or other specialty treatment programs;
- genetic testing and related services unless determined medically necessary by Group Health's medical director;
- hearing aid replacement parts, batteries and maintenance costs;
- herbal supplements;
- home health care services involving:
  - any care provided by a member of the patient's family;
  - any other services rendered in the home that aren't specifically listed as covered under "Home Health Care";
  - care in a nursing home or convalescent facility;
  - custodial care or maintenance care;
  - housekeeping or meal services; and
  - private duty or continuous nursing care in the patient's home;
- home pregnancy tests;
- hospice services involving:
  - any services provided by members of the patient's family;
  - custodial care or maintenance care;
  - financial or legal counseling (e.g., estate planning or will preparation);
  - funeral arrangements; and
  - homemaker, caretaker or other services not solely related to the patient, such as:
    - housecleaning or upkeep;

    - meal services;
    - sitter or companion services for either the patient or other family members; and
    - transportation;
- hypnotherapy or any related services;
- infertility treatment; sterility; or sexual dysfunction diagnostic testing or treatment, including Viagra; penile implants; vascular or artificial reconstruction; and procedures to reverse voluntary sterilization;
- injuries to teeth caused by biting or chewing;
- jaw abnormalities or malocclusions;
- medicine or injections for anticipated illness while traveling;
- mental health services involving:
    - custodial care;
    - marital and family counseling;
    - specialty programs for mental health therapy not provided by Group Health; and
    - treatment of sexual disorders;
- neurodevelopmental and rehabilitation services involving:
    - implementation of home maintenance programs;
    - long-term rehabilitation programs;
    - programs for the treatment of learning problems;
    - recreational, life-enhancing, relaxation or palliative therapy;
    - specialty rehabilitation programs not provided by Group Health; and
    - therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning;
- non-emergency use of an emergency facility;
- organ transplant costs involving donor costs reimbursable by the organ donor's insurance plan, and living expenses and transportation expenses not listed under "Transplants";
- orthopedic shoes not attached to an orthopedic appliance or arch supports (including custom shoe inserts or their fitting, except for therapeutic shoes and shoe inserts for severe diabetic foot disease);
- orthoptic therapy (i.e., eye training);
- out-of-network expenses exceeding usual, customary and reasonable (UCR) charges;
- over-the-counter drugs, except for tobacco cessation drugs;

- personal comfort items, such as phones or television;
- physical exams, immunizations or evaluations primarily for the protection and convenience of third parties, including for obtaining or continuing employment or insurance or government licensure;
- pre- and post-surgical nutritional counseling and related weight-loss programs;
- prescribing and monitoring of drugs;
- prescription drugs, specifically:
  - dietary drugs;
  - drugs for cosmetic uses;
  - drugs for treatment of sexual dysfunction;
  - drugs not approved by the FDA and in general use as of March 1 of the previous year;
  - over-the-counter drugs; and
  - vitamins, including prescription vitamins;
- preventive care visits to acupuncturists and naturopaths, and services not within the scope of their license;
- rehabilitative services involving:
  - chronic conditions;
  - implementation of home maintenance programs;
  - programs for the treatment of learning problems;
  - recreational, life-enhancing, relaxation or palliative therapy;
  - specialty treatment programs not provided by Group Health; and
  - therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning;
- routine foot care;
- services and supplies covered by other insurance policies, including any vehicle, homeowner, property or other insurance policy whether or not a claim is made pursuant to:
  - medical coverage, medical "no fault" coverage, personal injury protection coverage or similar medical coverage contained in the policy; and/or
  - uninsured motorist or underinsured motorist coverage contained in the policy;
- services and supplies resulting from the loss or willful damage to covered appliances, devices, supplies or materials provided by Group Health;
- services performed by a network provider or oral surgeon involving:
  - reduction of a fracture or dislocation of the jaw or facial bones;

  - excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, or roof or floor of the mouth; and
  - incision of salivary glands and ducts;
- services covered by the national health plan of any other country;
- services provided by government agencies, except as required by federal or state law;
- sexual disorder treatment;
- TMJ-related expenses involving:
  - all dental services (except as noted under "Temporomandibular Joint (TMJ) Disorders"), including orthodontic therapy;
  - orthognathic (jaw) surgery in the absence of a TMJ diagnosis or severe obstructive sleep apnea diagnosis, except for newborn infants with congenital anomalies; and
  - treatment for cosmetic purposes;
- transgender cosmetic surgery, including treatment for complications resulting from cosmetic surgery and related travel;
- transplant costs and services involving:
  - donor costs reimbursable by the organ donor's insurance plan;
  - living expenses;
  - transportation expenses (except as listed under "Transplants"); and
  - treatment of donor complications;
- weight reduction programs and/or exercise programs and specialized nutritional counseling; and
- work-incurred injury, illness or condition treatment.

Filing a Claim

If you receive care from a network provider, the provider submits claims for you.

If you receive emergency services from an out-of-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to Group Health or have the provider submit one for you. Claim forms are available from Group Health.

When submitting any claim, you need to include your itemized bill. It should show:

- patient's name;
- provider's tax ID number;
- diagnosis or ICD-9 code;
- date of service/supply; and
- itemized charges from the provider for the services/supplies received.

You also need to provide:

- your name (if you're not the patient);
- your Social Security number (or unique ID number if assigned one by Group Health); and
- group number (shown on your Group Health ID card and available from Benefits, Payroll and Retirement Operations).

For prompt payment, submit all claims as soon as possible to:

Group Health
P.O. Box 34585
Seattle, WA 98124-1585.

Group Health will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

How Group Health Reviews Claims

Group Health will review your claim and notify you or your provider in writing within the following time frames:

- **within 72 hours for urgent claims.** Urgent claims are those where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. You'll be notified of the claim review decision by phone and later by a written notice.
- **within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where Group Health requires you to obtain approval of the benefit before receiving the care. Group Health may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claims administrator as an ongoing course of treatment or to be provided over a certain period.
- **within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. Group Health may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

If Group Health Approves the Claim

If the claim is approved and there is no indication that the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

If Group Health Denies the Claim

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that Group Health reviewed in making the determination. (For information about appeals, see "Group Health" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

Dental Plan

King County offers you dental coverage that encourages regular preventive care, helps you maintain healthy teeth and gums, and helps you pay for a broad range of other dental services when treatment is needed.

As a benefit-eligible employee, you receive dental benefits through Delta Dental of Washington, a member of the Delta Dental Plans Association.

How the Dental Plan Works

With the dental plan, you can use any dentist you want, but your out-of-pocket expenses are usually lower when you use a Delta Dental participating dentist. (For information about participating dentists, see "Participating Dentists").

Any Delta Dental participating dentist will automatically file your claims for you. Most dentists in Washington are participants in one or more of the Delta Dental networks.

The dental plan increases what it pays for most services through an incentive program, as long as you see a dentist each year for a covered service:

- for diagnostic and preventive services, as well as basic services, the dental plan begins paying at 70% and increases 10% in January of each year until the dental plan pays 100%; and
- for major services (excluding prosthodontics), the dental plan begins paying at 70%, then increases to 80%, and then again to 85%.

Your Dental Benefits at a Glance

The following table shows what the dental plan pays for covered services and supplies under the dental plan when you use a Delta Dental participating dentist, and identifies related deductibles, coinsurance and maximums.

The following table does not show what the dental plan pays when you use a non-participating dentist. For more details, contact Delta Dental of Washington at 1-866-229-4102.

Plan Feature	
Annual deductible (doesn't apply to diagnostic and preventive services, orthodontic services or accidental injuries)	$25/person; $75/family
Annual maximum benefit (doesn't apply to orthodontic or TMJ services)	$2,500/person
Covered Expenses	**Dental Plan Pays**

Diagnostic and preventive services • Exam and cleaning, twice/calendar year • Oral health assessment • Periodontal cleaning and maintenance up to 4 times/calendar year combined (under certain oral health conditions) • Complete X-rays every 3 years • Supplementary bitewing X-rays, twice/calendar year	70%–100%, based on patient's incentive level (deductible doesn't apply)
Basic services • Crowns (stainless steel) • Extractions • Fillings • Periodontics • Root canals	70%–100%, based on patient's incentive level
Major services • Crowns (gold, porcelain) (contact Delta Dental for limitations and exclusions) • Onlays • Periodontics—occlusal (night) guard (under certain oral health conditions)	70%–85%, based on patient's incentive level 50% occlusal guard (incentive levels don't apply) Your medical plan may provide additional occlusal guard coverage.
Major services—Prosthodontics • Dentures • Fixed bridges • Implants	70% (incentive levels don't apply)
Orthodontic services for covered adults and children	50% up to a $2,500 lifetime maximum (deductible, incentive levels and annual maximums don't apply) Not more than $1,250 will be paid during the initial stage of treatment; the remaining plan benefit is paid 7 months after the initial stage if the covered participant still meets eligibility requirements.
Temporomandibular joint (TMJ) disorders	50% up to a $500 lifetime maximum for non-surgical treatment and appliances (incentive levels and annual maximums don't apply) Your medical plan may provide additional TMJ coverage.
Accidental injury	100% for covered expenses incurred within 180 days of accident (deductible doesn't apply)

Using the Dental Plan

When you make an appointment, tell your dentist that you're covered by the Delta Dental plan and provide your Social Security number (or alternate ID if you've requested one) and your dental plan group number, which is 00152.

Participating Dentists

To receive the full benefits of the dental plan, you must choose a Delta Dental participating dentist who will file a claim for you.

Choosing a Participating Dentist

The dental plan has an extensive network of participating dentists. To locate a Delta Dental dentist or find out if your dentist is part of the Delta Dental network, visit the Delta Dental Web site or call Delta Dental.

Participating dentists in the dental plan include Delta Dental Premier dentists and Delta Dental PPO dentists. You will pay the least out-of-pocket if you see a dentist in the PPO network. Visit www.deltadentalwa.com to locate a participating dentist.

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive dental coverage for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations.

Paying for Your Care

Because you don't receive an ID card for your dental plan, you'll need to tell your dentist you're covered by the King County Delta Dental plan (group number 00152). You must provide either your Social Security number or an alternative ID (if you've requested one) to your dentist for verification of your benefit eligibility. From there, your dentist (if a Delta Dental participating dentist) will handle all of your claims and any predetermination of benefits you may have requested.

Deductible

The "annual deductible" is the amount you must pay each year toward covered services before the dental plan begins paying. The dental plan deductible is $25 per covered person, up to $75 per family per year, for claims involving crowns, extractions, fillings, periodontics, root canals, onlays, dentures, fixed bridges, implants, occlusal (night) guards and temporomandibular joint disorder (TMJ) treatments. The deductible doesn't apply to diagnostic and preventive services, orthodontic services or treatment for accidental injuries.

Coinsurance

After you've paid the deductible, if applicable, you begin paying a percentage—the coinsurance—of the cost of your dental care based on the incentive level you've earned and the type of service you're receiving.

Benefit Maximums

The "benefit maximum" is the most the dental plan will pay for most covered services each calendar year. The dental plan's annual benefit maximum is $2,500 per covered person.

Two services have lifetime maximums, which don't apply to the calendar-year benefit maximum:

- orthodontic treatment at $2,500 per person; and

- TMJ treatment at $500 per person.

Your benefit maximum is calculated based on the services completed in a calendar year. Charges for dental procedures such as crowns and bridgework that require multiple treatment dates are considered incurred on the date the service is completed even if it began in the previous calendar year.

Incentive Program

Delta Dental increases the payment levels for your benefits through an incentive program. As long as you see your dentist for a covered service each year:

- for diagnostic and preventive services, as well as basic services, the dental plan begins paying at 70% and increases 10% in January of each year until the dental plan pays 100%; and
- for major services (excluding prosthodontics), the dental plan begins paying at 70%, then increases to 80%, and then again to 85%.

If you don't see a dentist for a covered service during the year, your payment level is reduced to the next lower payment level under which your last claim was paid, but never below 70%. For example, if your payment level was 80% in 2014 but you didn't see your dentist for a covered service that year, your payment level in 2015 would be reduced from 80% to 70%.

If you're a new employee, coverage begins at the 70% incentive level—**levels "earned" under another group plan don't apply to the county's dental plan.** However, incentive levels are adjusted based on previous participation in the county's dental plan if you're a:

- covered spouse/domestic partner or dependent of a King County employee and become employed by the county;
- recalled or reinstated employee who returns to work within two years of previous county employment; or
- rehired employee who has continued county coverage uninterrupted under COBRA between your previous county employment and the date of your rehire (if county coverage has been interrupted, new employee incentive levels apply).

The following table summarizes how the incentive program works.

If you receive...	The dental plan pays ...
Diagnostic and preventive services **Basic services**	• 70% in the first year • 80% in the second year • 90% in the third year • 100% in the fourth year and each year thereafter
Major services	• 70% in the first year • 80% in the second year • 85% in the third year and each year thereafter

IMPORTANT!

Payment levels for major prosthodontic services, orthodontia, TMJ treatment, occlusal (night) guards and accidental injury aren't determined by the incentive program.

Other Features of the Dental Plan

It's important to understand other features of the dental plan such as preauthorization and the oral health assessment program. Having a better understanding of how the dental plan works will enable you to use the plan wisely and take advantage of all the benefits that the plan has to offer.

Predetermination of Benefits

If you think your dental care will exceed $200 or you need orthodontic or TMJ services, ask your dentist to submit a standard Delta Dental claim form for predetermination of benefits. By doing this, you'll learn in advance what procedures are covered, the amount the dental plan may pay toward the treatment and the amount you'll be expected to pay. Final payment may differ from the estimate based on several factors, such as actual services received, amount of annual deductible outstanding, benefits paid by the primary plan, and applicable plan limits.

Delta Dental will provide notice of the claim decision within 15 days after receiving your claim form. **A predetermination of benefits is not a guarantee of payment.**

For an emergency, immediate treatment is allowed without predetermination of benefits, and the claim is evaluated after treatment has begun.

Knowing What's Covered and What's Not

The following provides guidelines about what is considered a "covered expense" and what expenses aren't covered.

If professional dental standards indicate the condition can be treated by a less costly alternative to the service proposed by your dentist, the dental plan will limit benefits to the less costly alternative, as determined by Delta Dental on a case-by-case basis. You're responsible for any treatment costs exceeding the allowable amounts paid by the dental plan.

Covered Expenses

MORE INFORMATION

For a complete description of the benefits offered under the dental plan, please contact Delta Dental of Washington at 1-866-229-4102.

To be covered, expenses must be medically necessary for treatment, diagnosis or prevention of a dental condition.

The dental plan covers expenses for the following services. Please contact Delta Dental of Washington for details, limitations and exclusions:

- Class I: preventive and diagnostic services;
- Class II: basic services; and
- Class III: major services.

Class I: Preventive and Diagnostic Services

Diagnostic Services

The dental plan covers the following diagnostic services:

- routine examination (periodic oral evaluation), twice per calendar year;
- comprehensive oral evaluation once in a three-year period as one of the two covered annual routine examinations per dental office. Additional comprehensive oral evaluations will be considered routine examinations. You won't be responsible for any difference in cost between a comprehensive oral evaluation and routine examination when services are provided by a Delta Dental participating dentist;
- X-rays, as follows:
  - a complete series of X-rays (including any number of intraoral X-rays, billed on the same date of service, that equals or exceeds the allowed fee for a complete series) or panorex X-rays, once in a three-year period; and
  - supplementary bitewing X-rays, twice per calendar year;
- emergency examination;
- examination performed by a specialist in an American Dental Association recognized specialty; andX-rays related to temporomandibular joint (TMJ) disorders are covered under the TMJ benefit.

Preventive Services

The dental plan covers the following preventive services:

- prophylaxis (cleaning) and/or periodontal maintenance, twice per calendar year;
- fissure sealants for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface, once per tooth in a two-year period;
- remineralization, up to four times per calendar year;
- topical application of fluoride or preventive therapies (e.g., fluoridated varnishes), with either service, but not both, covered twice per calendar year; and
- space maintainers when used to maintain space for eruption of permanent teeth.

IMPORTANT!

Under certain conditions, prophylaxis or periodontal maintenance (but not both) may be covered up to four times per calendar year.

Periodontics

The dental plan covers the following periodontic services:

- prescription strength fluoride toothpaste; and
- antimicrobial mouth rinse, once per periodontal treatment.

Prescription strength fluoride toothpaste and antimicrobial mouth rinse are covered following periodontal surgery or other covered periodontal procedures when dispensed in a dental office. Proof of a periodontal procedure must accompany the claim or your Delta Dental history must show a periodontal procedure within the previous 180 days. However, antimicrobial mouth rinse is covered for pregnant women whether or not a periodontal procedure has been performed.

Class II: Basic Services

General Anesthesia

The dental plan covers general anesthesia when administered by a licensed dentist or other Delta Dental-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington or as determined by the state in which the services are rendered. Either general anesthesia or intravenous sedation, but not both, is covered when performed on the same day.

Intravenous Sedation

The dental plan covers intravenous sedation when administered by a licensed dentist or other Delta Dental-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington or as determined by the state in which the services are rendered. Either general anesthesia or intravenous sedation, but not both, is covered when performed on the same day.

Palliative Treatment

The dental plan covers palliative treatment for pain.

Restorations

The dental plan covers the following restorations:

- amalgam restorations (fillings) and, in anterior (front) teeth, resin-based composite or glass ionomer restorations (fillings) for treatment of:
  - carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay);
  - fracture resulting in significant loss of tooth structure (missing cusp);
  - fracture resulting in significant damage to existing restoration;
- restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service;
- resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids. If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspids as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, and any difference in cost will be your responsibility; and
- stainless steel crowns, once in a two-year period from the date of service.

(If teeth are restored with crowns, veneers, inlays or onlays, see "Restorations" in "Class III: Major Services")

Oral Surgery

The dental plan covers the following oral surgery services:

- removal of teeth;
- preparation of the mouth for insertion of dentures; and
- treatment of pathological conditions and traumatic injuries of the mouth.

(For more information, see "General Anesthesia" and "Intravenous Sedation" in "Class II: Basic Services")

Periodontics

The dental plan covers the following periodontic services:

- surgical and non-surgical procedures for treatment of the tissues supporting the natural teeth; services covered include periodontal scaling/root planing and periodontal surgery;
  - periodontal scaling/root planing is covered once in a 12-month period;
  - periodontal surgery (per site) is covered once in a three-year period; and
  - soft tissue grafts (per site) are covered once in a three-year period;
- limited adjustments to occlusion (8 teeth or less), once in a 12-month period; and
- Delta Dental-approved localized delivery of antimicrobial agents, up to two teeth per quadrant and up to twice per tooth per calendar year.

Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing at least six weeks but not more than six months—or you must have been in active supportive periodontal therapy—before such treatment begins.

(For information about periodontal maintenance benefits, see "Class I: Preventive and Diagnostic Services" on page 101. For information about complete occlusal equilibration and occlusal (night) guards, see "Periodontics" in "Class III: Major Services")

Endodontics

The dental plan covers the following endodontic services:

- procedures for pulpal and root canal treatment, with root canal treatment on the same tooth covered once in a two-year period; and
- pulp exposure treatment, pulpotomy and apicoectomy.

Re-treatment of the same tooth is allowed when performed by a different dentist at a different dental office.

(For details relating to root canals that are placed in conjunction with a prosthetic appliance, see "Prosthodontics" in "Class III: Major Services")

Class III: Major Services

Periodontics

Under certain conditions, the dental plan covers occlusal (night) guards, repair and relines of occlusal (night) guards, and complete occlusal equilibration. Keep in mind that:

- occlusal (night) guards are covered once in a three-year period; and
- repairs and relines done more than six months after the initial placement are covered.

Restorations

The dental plan covers the following restorations:

- crowns, veneers, inlays (as a single tooth restoration, with limitations) or onlays for the treatment of carious lesions (that is, visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials, such as amalgam or resin-based composites;
- crown buildups, once in a two-year period when more than 50% of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology; and
- post and core, once in a five-year period on the same tooth.

While the dental plan covers the restoration services listed above, there are a number of limitations to that coverage:

- crowns, veneers or onlays on the same teeth are covered once in a five-year period from the seat date;
- if a tooth can be restored with a filling material such as amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided;
- Delta Dental will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory-processed resin inlay (as a single tooth restoration, with limitations), onlay, veneer or crown;
- payment for crowns, veneers, inlays (as a single tooth restoration, with limitations) or onlays will be paid on the date they're permanently cemented into place on the tooth; and
- inlays (as a single tooth restoration, with limitations) will be considered a cosmetic procedure and an amalgam allowance will be made, and any difference in cost will be your responsibility.

Prosthodontics

The dental plan covers the following prosthodontic services:

- dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device; and
- surgical placement or removal of implants or attachments to implants.

While the dental plan covers the prosthodontic services listed above, there are a number of limitations to that coverage:

- replacement of an existing prosthetic device is covered once every five years from the delivery date and only if it is unserviceable and cannot be made serviceable;
- inlays are covered on the same teeth once every five years from the delivery date only when used as a retainer for a fixed bridge;

- payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge) and removable partial dentures will be made on the delivery date;
- replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant;
- Delta Dental will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment;
- Delta Dental will allow the amount of a reline toward the cost of an interim partial or full denture; after placement of the permanent prosthesis, an initial reline will be covered after six months;
- root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III payment level (for coverage details, see "Your Dental Benefits at a Glance");
- if a more elaborate or precision device is used to restore the cast of a partial denture, Delta Dental will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided; and
- denture adjustments and relines done more than six months after the initial placement are covered; subsequent relines or rebases, but not both, will be covered once in a 12-month period.

Other Benefits

Orthodontic Services

The dental plan covers the following orthodontic services for covered adults and children:

- treatment of malalignment of teeth and/or jaws;
- exams (initial, periodic, comprehensive, detailed and extensive);
- X-rays (intraoral, extraoral, diagnostic radiographs, panoramic);
- diagnostic photographs;
- diagnostic casts (study models);
- cephalometric films; and
- orthodontic records.

Payment is limited to:

- completion, or through limiting age, whichever occurs first;
- treatment received after coverage begins (claims must be submitted to Delta Dental within six months of the start of coverage, which is based on the date of initial banding); and
- termination of the treatment plan before completion of the case or termination of this contract.

Payment for treatment that begins before the date of initial banding may be prorated and deducted from the lifetime maximum.

BEFORE TREATMENT BEGINS

It is strongly suggested that an orthodontic treatment plan be submitted to Delta Dental, together with a predetermination of benefits request, before treatment begins. Predetermination of benefits is not a guarantee of payment.

Temporomandibular Joint Treatment

The dental plan covers certain treatments for temporomandibular joint (TMJ) disorders that have one or more of the following characteristics:

- pain in the musculature associated with the temporomandibular joint;
- internal derangements of the temporomandibular joint;
- arthritic problems with the temporomandibular joint; or
- an abnormal range of motion or limitation of motion of the temporomandibular joint.

Covered services include, but aren't limited to, the following non-surgical procedures:

- TMJ examination;
- X-rays (including TMJ film and arthrogram);
- temporary repositioning splint;
- occlusal orthotic device;
- removable metal overlay stabilizing appliance;
- stabilizing appliance;
- occlusal equilibration;
- arthrocentesis; and
- manipulation under anesthesia.

To be covered, these services must be:

- appropriate, as determined by Delta Dental for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint:
  - pain;
  - infection;
  - disease;
  - difficulty speaking; or
  - difficulty chewing or swallowing food;
- recognized as effective, according to the professional standards of good dental practice; and

- not experimental or primarily for cosmetic purposes.

Any procedure defined as a TMJ service above but that may otherwise be a service covered under another class of coverage will be considered covered by that class of coverage and not covered under TMJ treatment.

BEFORE TREATMENT BEGINS

It is strongly recommended that a TMJ treatment plan be submitted to Delta Dental, together with a predetermination of benefits request, before treatment begins. Predetermination of benefits is not a guarantee of payment.

Accidental Injury

The dental plan pays 100% of covered Class I, Class II and Class III expenses directly resulting from an accidental bodily injury, up to the annual maximum, if the diagnosis and treatment is performed/incurred within 180 days after the accident. (A bodily injury doesn't include teeth broken or damaged while chewing or biting on foreign objects.)

The accidental bodily injury and treatment must have occurred while you were covered under this plan. Payment for accidental injury claims will not exceed the maximum.

Expenses Not Covered

The dental plan doesn't cover the following dental services and supplies:

- any treatment for which you failed to obtain a required examination from a Delta Dental-appointed consultant dentist;
- application of desensitizing agents;
- analgesics, such as nitrous oxide, conscious sedation, or euphoric drugs, injections or prescription drugs;
- behavior management;
- bleaching of teeth;
- broken appointments;
- certain diagnostic services and supplies, specifically:
  - consultations or study models;
- certain preventive services and supplies, specifically:
  - plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits); and
  - replacement of a space maintainer previously paid for by the dental plan;
- certain prosthodontic services and supplies, specifically:
  - cleaning of prosthetic appliances;
  - duplicate dentures;
  - personalized dentures;
  - copings; and

  - crowns in conjunction with overdentures;
- certain oral surgery services and supplies, specifically:
  - bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth;
  - bone replacement graft for ridge preservation;
  - materials placed in tooth extraction sockets for the purpose of generating osseous filling; and
  - tooth transplants;
- certain orthodontic services and supplies, specifically:
  - replacement or repair of an appliance; and
  - services considered inappropriate and unnecessary, as determined by Delta Dental;
- certain restorative services and supplies, specifically:
  - crown buildups within two years of a restoration on the same tooth;
  - a crown used for purposes of recontouring or repositioning a tooth to provide additional retention for a removable partial denture, unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment;
  - crowns or onlays when used to repair microfractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present;
  - crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology;
  - overhang removal, copings, recontouring or polishing of a restoration; and
  - restorations or appliances necessary to correct vertical dimension, alter the morphology (shape) or restore the occlusion, including:
    - restoration of tooth structure lost from attrition, abrasion or erosion; and
    - restorations for malalignment of teeth;
- completing claim forms;
- dentistry for cosmetic reasons;

- experimental services or supplies—experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation or observation; in determining whether services are experimental, Delta Dental, in conjunction with the American Dental Association, will consider whether the services:
  - are in general use in the dental community in the State of Washington;
  - are under continued scientific testing and research;
  - show a demonstrable benefit for a particular dental condition; and
  - are proven to be safe and effective;

  any denial of benefits by Delta Dental on the grounds that a given procedure is deemed experimental:
  - may be appealed to Delta Dental; and
  - Delta Dental must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision; and
  - the 20-day period may be extended only with your written consent;
- general anesthesia/intravenous (deep) sedation for routine post-operative procedures and except as specified by Delta Dental for certain oral, periodontal or endodontic surgical procedures (general anesthesia is covered when medically necessary for covered children through age 6 or for a physically or developmentally disabled person, when in conjunction with covered dental procedures);
- habit-breaking appliances;
- hospitalization charges and any additional fees charged by a dentist for hospital treatment;
- services for injuries or conditions that are compensable under workers' compensation or employers' liability laws, and services that are provided to you by any federal or state or provincial government agency or provided without cost to you by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, Section 1902 of the Social Security Act; and
- services or supplies to the extent that benefits are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection, commercial liability, homeowner's policy or other similar type of coverage.

Filing a Claim

If you receive care from a Delta Dental participating dentist, the dentist will submit a claim for you and obtain any necessary predetermination for certain procedures and services.

If you receive services from a non-participating dentist, you may be required to pay the dentist in full, and it's your responsibility to submit an American Dental Association-approved claim form to Delta Dental or have the provider submit one for you. Claim forms are available from Delta Dental.

When submitting any claim, you need to include your itemized bill. It should show:

- patient's name;
- provider's tax ID number;
- diagnosis or CDT code;
- date of service/supply; and
- itemized charges from the provider for the services and/or supplies received.

You also need to provide:

- your name (if you're not the patient);
- your Social Security number (or unique identifier number if you've requested one); and
- group number 00152.

For prompt payment, submit all claims as soon as possible to:

Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983.

The dental plan won't pay a claim submitted more than six months after the date of service and/or supply. If you can't meet the six-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

How Delta Dental Reviews the Claim

Delta Dental will review your claim and notify you or your provider in writing within the following time frames:

- **within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that have already occurred. The dental plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

If Delta Dental Approves the Claim

If the claim is approved and there is no indication that the bill has been fully paid, payment for covered services is made to the dentist. If the bill indicates that full payment has been made to the dentist, payment for covered services is made directly to you.

If Delta Dental Denies the Claim

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that were reviewed in making the determination. (For more information about appeals, see "Dental" in "Health Care Plans" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

Vision Plan

King County offers a vision plan that makes it easy for you to get the eye care you need.

As a benefit-eligible employee, you receive vision benefits through Vision Service Plan (VSP).

How the Vision Plan Works

With the vision plan, you can use any eye care provider you want, but your out-of-pocket expenses are usually lower if you see a VSP provider. Plus, a VSP provider automatically files your claims for you.

Your benefits with the vision plan are based on a 12-month cycle rather than a calendar year—for example, if you have your first eye exam in June, you'll be eligible for your next eye exam the following June.

Though Group Health provides routine vision exams under its medical plan; it does not provide any of the other vision benefits shown in "Your Vision Benefits at a Glance" on page 112. Those benefits are provided by VSP. In addition, VSP providers may not accept a Group Health prescription for lenses.

Your Vision Benefits at a Glance

The following table shows what the vision plan pays for covered eye care services and eyewear, and identifies related limits.

Vision Plan		
Covered Expenses	**If you see a VSP provider, you pay a $10 copay and the plan pays the amount listed below**	**If you see a non-VSP provider, you pay the bill in full and the plan reimburses you the amounts listed below, minus a $10 copay**
Exam (once every 12 months)	100%	Up to $50
Eyeglass lenses (one pair every 12 months)		
• Single vision	100%	Up to $50
• Lined bifocal	100%	Up to $75
• Lined trifocal	100%	Up to $100
• Progressive lenses	100%	Up $75
• Lenticular	100%	Up to $125
• Polycarbonate lenses for covered children	100%	Not covered
• Anti-reflective coating	100%	Not covered
• Color/mirror coating	100%	Not covered

Vision Plan		
• Scratch coating	100%	Not covered
• Tints/photochromic lenses	100%	Up to $5
• UV lenses	100%	Not covered
Eyeglass frames (once every 24 months)	Up to $130; if you choose a frame that costs more than the VSP allowable amount, you'll receive 20% off your out-of-pocket cost	Up to $70
Contact lenses (once every 12 months in place of eyeglass lenses and frames)		
• Elective (providers may bill you for contact lenses separately or they may include the lenses, fittings and follow-up fees in a single bill; all contact lens fees apply to the $130 maximum paid by the plan)	Up to $130 Cost for contact lens fitting and exam will not exceed $60	Up to $105
• Medically necessary	100% Preauthorization determined by VSP doctor	Up to $210 Preauthorization required
• Low-vision benefit	Two low vision supplemental exams every two years. VSP pays up to $125 for each exam 75% of the allowable amount up to a maximum of $1,000 (less any amount paid for supplemental testing) per covered individual every two years VSP doctor will determine if approved benefit criteria is met	Two low vision supplemental exams every two years. VSP pays up to $125 for each exam* 75% of the allowable amount up to a maximum of $1,000 (less any amount paid for supplemental testing) per covered individual every two years *
• Vision therapy benefit	$85 annually for one approved sensorimotor exam 75% of the allowable amount for approved therapy sessions up to the $750 limit annually. VSP doctor will determine if approved benefit criteria is met	$85 annually for one approved sensorimotor exam* 75% of the allowable amount for approved therapy sessions up to the $750 limit annually*

*If you choose to go to a non-VSP provider, you must pay the non-VSP provider up front and submit your claim for reimbursement. There is no guarantee of reimbursement, or that the amount VSP pays will be equal

to what you paid. When VSP receives the claim, it will be sent for review and, if benefit criteria is met, you will be paid back up to the amount VSP would pay a VSP provider.

VSP providers generally require two to three working days to make lenses, based on the lab and eyewear selected. If you don't have a back-up pair of glasses and would like a faster turnaround, your provider may be able to accommodate you, depending on its arrangements with the lab. Because the cost and arrangements vary by provider, contact your VSP provider for details.

Each time you receive contact lenses under the vision plan, you must wait 12 months before you're eligible for lenses (eyeglass or contact) and 24 months before you're eligible for frames.

HELPFUL HINT

If you're interested in getting both glasses and contacts, purchase the glasses first—then you can replace lenses (either eyeglass or contact) each year.

Using the Vision Plan

When you enroll in the vision plan, you may receive benefits from a VSP or a non-VSP provider. However, you will pay less out-of-pocket and receive more covered services at a network provider. Visit www.vsp.com to determine if your provider is in the network. When you make an appointment, be sure to identify yourself as a VSP member and give the employee's Social Security number (or alternate ID if one has been requested).

The VSP Network

VSP has an extensive nationwide network of private-practice optometrists and ophthalmologists. To locate a VSP provider or find out if your provider is part of the VSP network, visit the VSP Web site or call VSP.

If Your Dependent Lives Away from Home

If your covered dependent lives away from home temporarily or permanently, he/she can still receive vision coverage through either a VSP (if available) or a non-VSP provider. Benefits depend on whether he/she chooses a VSP or non-VSP provider and are paid at the level shown in "Your Vision Benefits at a Glance."

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive vision coverage for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations.

Paying for Your Care

Since you don't receive an ID card for the vision plan, you'll need to tell your eye care provider that you're covered by the VSP vision plan for King County (group number 12029826). You must provide the employee's Social Security number (or alternate ID if one has been requested) to your provider for verification of your eligibility. From there, your provider (if he/she is a VSP provider) will handle your claims for you.

Copay

When you receive eye care services from a VSP provider, you pay a $10 copay. Most of your eye care expenses are covered at 100% after your copay when you see a VSP provider. When you see a non-VSP provider, you pay the bill in full, your $10 copay is deducted from the amount VSP reimburses you up to the plan allowance, and you pay any amount not covered by or exceeding the plan's benefits.

Knowing What's Covered and What's Not

The following provides guidelines about what is considered a "covered expense" and what expenses aren't covered.

Covered Expenses

The vision plan covers expenses for the following services:

- contact lenses—elective;
- necessary contact lenses are covered in full when VSP benefit criteria is met and verified by a VSP network doctor for eye conditions that would prohibit the use of glasses. The conditions covered include aphakia, anisometropia, high ametropia, nystagmus, keratoconus, aniridia, corneal transplant, hereditary corneal dystrophies and other eye conditions that make contact lenses necessary;
- exam—a complete analysis of the eye and related structures, including optional retinal screening, to determine the presence of vision problems or abnormalities;
- eyeglass lenses—single vision, lined bifocal, lined trifocal, progressive and lenticular, including polycarbonate lenses for covered children, anti-reflective/scratch coatings, mirror and color coating, UV protection and tinted/photochromic lenses;
- eyeglass frames; and
- plano sunglasses—only available from a VSP provider when you're eligible for frames and have had PRK, Lasik or Custom Lasik vision correction surgery.

Low-Vision Benefit

A low-vision benefit is available if your loss of vision is sufficient enough to prevent you from reading, moving around in unfamiliar surroundings and completing desired tasks. Those with low vision have impaired vision that's not fully treatable by medical or surgical means or by conventional eyewear or contact lenses.

Coverage includes:

- two low-vision supplemental exams every two years (VSP pays up to $125 for this exam); and
- an allowance for low-vision aids, including prescription services and optical/non-optical aids, every two years.

You're responsible for any charges exceeding the amounts that VSP pays.

The maximum benefit per person is $1,000 every two years. If low-vision supplemental testing is approved, VSP will cover the exams up to $125 every two years. If low-vision aids are approved, VSP will pay 75% of the approved amount up to a maximum of $1,000, less any amount paid for supplemental testing, every two years. You're responsible for the remaining 25% of the approved amount, plus any amount over the maximum $1,000 benefit.

If you use a non-VSP provider, you must pay the provider at the time of service and submit a claim to VSP for reimbursement. There is no guarantee of reimbursement or that you'll be reimbursed at the amount you paid. If VSP approves your claim following a post-authorization review, you'll be paid up to the amount that VSP would pay a VSP provider. For example, if you pay $200 for a supplemental evaluation, you'll be reimbursed for only the maximum payable amount of $125.

Vision Therapy Benefit

A vision therapy benefit, called optometric vision therapy, is available to you if you have severe visual problems associated with sensory and/or muscular deficiencies of the visual system.

Optometric vision therapy is a treatment plan used to correct or improve specific dysfunctions of the vision system. It includes, but is not limited to, the treatment of:

- strabismus (turned eye);
- other dysfunctions of binocularity (eye teaming);
- amblyopia (lazy eye);
- accommodation (eye focusing);
- ocular motor function (general eye movement ability); and
- visual-perception-motor abilities.

Optometric vision therapy is based upon a medically necessary plan of treatment designed to improve specific vision dysfunctions determined by standardized diagnostic criteria. Treatment plans encompass lenses, prisms, occlusion (eye patching) and other appropriate materials, modalities and equipment.

VSP pays up to a maximum of $85 annually for one approved supplemental evaluation and up to an additional $750 annually for approved vision therapy. VSP pays 75% of the allowable amount for approved therapy visits, and you are responsible for the remaining 25%.

If you use a non-VSP provider, you must pay the provider at the time of service and submit a claim to VSP for reimbursement. There is no guarantee of reimbursement or that you'll be reimbursed at the amount you paid. If VSP approves your claim following a post-authorization review, you'll be paid up to the amount that VSP would pay a VSP provider. For example, if you pay $200 for a supplemental evaluation, you'll be reimbursed for only the maximum payable amount of $85.

Discounts

The vision plan provides discounts for a number of services.

- **extra frames and prescription lenses.** You may purchase an unlimited number of additional pairs of prescription glasses and/or non-prescription sunglasses from a VSP provider at a 30% discount when purchased on the same day as your exam by a VSP provider. Otherwise, you may purchase additional pairs of prescription glasses and/or non-prescription sunglasses, including non-covered lens options, from your VSP provider at a 20% discount. To receive the 20% discount, you must make the additional purchase within 12 months after your initial exam by a VSP provider.
- **exam for prescription contact lenses.** If you see a VSP provider for a contact lens fitting and evaluation exam for the purpose of fitting you for prescription contact lenses, you'll receive a 15% discount toward the exam and any follow-up services.

  Contact lens fitting and evaluation exam will not exceed $60 when services are received from a VSP Provider.

  Ask your eye care provider to explain your options before you receive care.
- **retinal screening.** If you see a VSP provider for your annual eye exam, you may request retinal screening, for which you pay no more than $39, as an enhancement to dilation in determining the presence of vision problems or abnormalities.
- **laser vision correction.** VSP has arranged for plan members to receive laser vision correction from VSP-approved surgeons and laser centers for a discounted fee. Discounts vary by location but average 15% to 20%. The laser centers may offer an additional price reduction, where VSP members receive 5% off the advertised price if it's less than the usual discounted price. Post-procedure care is coordinated between your VSP provider (optometrist or ophthalmologist) and your VSP surgeon and laser center. To obtain laser vision services:
  - call your VSP provider to check if he/she participates in the program, or contact VSP to locate a participating provider; and

  - schedule a free screening and consultation on the advantages and risks of laser vision correction.

  Your VSP provider will give preoperative care and make arrangements with the VSP-approved surgeon and laser center. While the screening and consultation are complimentary, your VSP provider may charge a discounted exam fee of up to $100 if you have a preoperative exam and don't proceed with the surgery.

Expenses Not Covered

The vision plan doesn't cover:

- costs that exceed plan allowances;
- exams or eyewear required as a condition of employment;
- extra-cost items—the vision plan is designed to pay the cost of visual rather than cosmetic needs; a VSP provider can tell you the additional charges that you'll pay for:
  - amounts over the low-vision benefit maximum;
  - frames above the plan allowance; and
  - optional cosmetic services, procedures and eyewear;
- lenses—blended;
- medical or surgical treatment of the eye;
- orthoptics or vision training and any associated supplemental testing;
- oversized lenses (61 mm or larger);
- plano (non-prescription) lenses, except if you have previously had PRK, Lasik or Custom Lasik vision correction surgery;
- polycarbonate lenses for covered adults;
- polycarbonate vision treatment of an experimental nature;
- corrective vision treatment of an experimental nature;
- perceptual training for a learning disability;
- replacement of lost or broken lenses and frames, except at scheduled intervals of once every 12 months for lenses (eyeglass or contact) and once every 24 months for frames—if frames are broken as new lenses are being inserted, VSP may cover the cost, depending on the age and condition of the broken frames; contact VSP for details;
- services or materials provided as the result of workers' compensation law or similar legislation, or obtained through or required by any government agency or program; and
- two pairs of glasses in place of bifocals.

Filing a Claim

If you receive care from a VSP provider, the provider submits claims for you. If you receive services from a non-VSP provider, you pay the provider in full, and it's your responsibility to submit a claim to VSP for reimbursement. You may submit a claim without a form, but if you would like one, claim forms are available from VSP by phone or at the VSP Web site.

When submitting any claim, you need to include your itemized bill. It should show:

- patient's name;
- date of service and/or supply; and
- copy of receipt showing itemized charges from the provider for the services and/or supplies received.

You also need to provide:

- group number 12-029826;
- the employee's name (if different from the patient's); and
- the employee's Social Security number (or alternate ID if one has been requested).

For prompt payment, submit all claims as soon as possible to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105.

The vision plan will not pay a claim submitted more than 12 months after the date of service and/or supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

How VSP Reviews the Claim

VSP will review your claim and notify you or your provider in writing within the following time frames:

- **within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that have already occurred.. VSP may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

If VSP Approves the Claim

If the claim is approved and there is no indication that the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates that full payment has been made to the provider, payment for covered services is made directly to you.

If VSP Denies the Claim

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that VSP reviewed in making the determination. (For information about appeals, see "Vision" in "Health Care Plans" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

CONTINUING COVERAGE UNDER COBRA

If you and/or your covered dependents lose your health care plan coverage through the county, the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) gives you and/or your covered dependents the right to continue coverage.

COBRA coverage is available in certain instances (called "qualifying events") where coverage under the following county health care plans would otherwise end:

- KingCare℠;
- Group Health;
- dental plan; and
- vision plan.
- Health care Flexible Spending Account (FSA)

This section of *Your King County Benefits* provides you with important information about your COBRA rights and how they apply to you and your covered dependents.

How COBRA Works

COBRA coverage is a continuation of health care plan coverage when coverage ends because of a life event known as a "qualifying event." When a qualifying event occurs, COBRA coverage must be offered to each "qualified beneficiary." You, your covered spouse/domestic partner and your covered children could become qualified beneficiaries if coverage under your county health care plan ends because of a qualifying event.

A notice describing COBRA rights is mailed to your home within 30 days after the time you first enroll in county coverage. When you become eligible for COBRA coverage, Benefits, Payroll and Retirement Operations will notify WageWorks of your status, and WageWorks will contact you with information about your COBRA options. WageWorks is the COBRA administrator for the county.

Who's Eligible for COBRA Coverage and Why

A qualified beneficiary is an employee, a spouse/domestic partner or a child who is covered by a county health care plan and who loses coverage because of a qualifying event.

Employee

As a benefit-eligible employee, you become a qualified beneficiary when you lose coverage under your county health care plan because of any of these qualifying events:

- a change in your job status, such as a reduction in hours;
- an unpaid leave of absence for more than 31 days; or
- your employment ends for retirement or any reason other than your gross misconduct and you were covered by active county benefits at the time of your retirement or separation from county employment.

Spouse/Domestic Partner

Your covered spouse/domestic partner becomes a qualified beneficiary when he/she loses coverage under your county health care plan because of any of these qualifying events:

- you die;
- there's a change in your job status, such as a reduction in hours;
- your employment ends for retirement or any reason other than your gross misconduct;
- you become entitled to Medicare (retiree medical coverage only); or
- you and your spouse divorce, or you end your domestic partnership (legal separation isn't a qualifying event).

Under county health coverage, you're allowed to continue covering your spouse even if you are separated so your spouse may have coverage until the divorce is final. However, if you discontinue coverage for your spouse in anticipation of a divorce and a divorce later occurs, your spouse loses coverage and does not become eligible for COBRA until the divorce is final. COBRA eligibility begins on the first day of the month following the divorce as long as enrollment and payment of premium have been timely.

You must complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days after your divorce is final. If King County isn't notified within 60 days, your former spouse won't be eligible for continuation of coverage. Your former spouse will have 60 days from the date his/her county coverage ends or from the date that WageWorks sends your former spouse notification of his/her COBRA eligibility, whichever is later, to enroll in COBRA.

Children

Your covered child becomes a qualified beneficiary when he/she loses coverage under your county health care plan because of any of these qualifying events:

- you die;
- there's a change in your job status, such as a reduction in hours;
- your employment ends for retirement or any reason other than your gross misconduct;
- you and your spouse divorce, or you end your domestic partnership (legal separation isn't a qualifying event);
- you become entitled to Medicare (retiree medical coverage only); or
- your child becomes ineligible for coverage as a dependent under your health care plan.

For your dependent to be eligible for COBRA, you must complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days of the date he/she becomes ineligible. If King County isn't notified within 60 days, your dependent won't be eligible for continuation of coverage.

How to Enroll in COBRA Coverage

When you qualify for COBRA coverage because you have a change in job status, leave county employment or retire, your qualifying event is reported to Benefits, Payroll and Retirement Operations through your Termination Notice, which you need to complete, or the county payroll report.

If you die while actively employed by the county, Benefits, Payroll and Retirement Operations will notify your eligible dependents of their COBRA rights.

For other qualifying events, such as divorce, dissolution of a domestic partnership or a child's loss of eligibility for coverage as a dependent, you must complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days of the qualifying event.

If these procedures aren't followed or if the online Discontinue Dependent Coverage form isn't completed by the last day of the 60-day notice period, any covered spouse/domestic partner or child who loses coverage will **not** be offered the option to elect COBRA coverage.

COBRA Enrollment Process

When Benefits, Payroll and Retirement Operations receives COBRA-qualifying information, it notifies WageWorks so that WageWorks can offer COBRA coverage to each qualified beneficiary and explain COBRA plan options and cost. Each qualified beneficiary has an independent right to elect COBRA coverage. As the covered employee, you may elect COBRA coverage on behalf of your qualified spouse/domestic partner. Parents may elect COBRA coverage on behalf of their qualified children.

If you're the covered employee and elect COBRA coverage, you pay the employee rate, your spouse/domestic partner pays the spouse/domestic partner rate and your children pay the children rate. If your spouse/domestic partner does not elect COBRA coverage, your children still pay the children rate.

If you're the covered employee and do not elect COBRA coverage, your qualified spouse/domestic partner and children may continue coverage under COBRA.

You have 60 days from the date your county coverage ends or from the date that WageWorks sends you notification of your COBRA eligibility, whichever is later, to elect COBRA coverage. If you elect COBRA coverage, it will pick up where your county coverage left off as long as enrollment and payment of premium have been timely.

You can continue COBRA coverage for only the county medical, dental, vision and health care FSA benefits you have on your last day of work. If you don't have medical coverage on your last day because you opted out of medical coverage, for example, you cannot enroll in medical coverage under COBRA.

OTHER COBRA BENEFITS

If you are continuing your health care plan coverage under COBRA, you may continue to use the county's Making Life Easier benefit. For more information about this benefit, contact Making Life Easier.

You also must pay for COBRA coverage.

For medical coverage under COBRA, you continue at the out-of-pocket expense level (Gold, Silver or Bronze) you had on your last day of employment.

You and/or your qualified dependents may continue coverage under both COBRA and Medicare or another group health care plan if the effective date of coverage under the other plan is before the COBRA election date.

COBRA AND FSA

If you're participating in a health care flexible spending account (FSA) you may continue to contribute to your FSA on an after-tax basis through the end of the calendar year. This allows you to receive reimbursements for expenses incurred during the remainder of the year. This option is available even if you do not elect medical, dental or vision under COBRA.

If you don't elect to continue your FSA contributions, you will be able to file claims for reimbursement up to the full amount of your annual election for expenses incurred through the end of the month in which your employment with the county ended. Claims may be filed through March 31 of the following year.

To continue your FSA, you need to contact WageWorks.

How Much COBRA Coverage Costs

Under the county health care plans, qualified beneficiaries who elect COBRA coverage must pay for it. Your plan options and their cost are explained in information you receive from WageWorks when you qualify for COBRA.

COBRA COST

COBRA cost information is available from Benefits, Payroll and Retirement Operations and its Web site.

If you elect COBRA coverage, you must make the initial premium payment within 45 days of your COBRA enrollment. **If you don't make the initial premium payment within those 45 days, your coverage will be terminated.** To expedite COBRA coverage so your claims may be paid sooner, you may attach your initial payment to the COBRA election form and return them both to WageWorks.

All other premiums are due on the first of the month. Coverage automatically ends if payment isn't made within 30 days. WageWorks will provide you with more detailed payment information when it first contacts you.

Once you've elected COBRA coverage and paid the initial premium within the 45-day time frame, COBRA coverage is retroactive to the first day of the month following your loss of coverage. There's no lapse in coverage—COBRA benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums. Any covered out-of-pocket expenses incurred before you enrolled in COBRA coverage may be reimbursable once you've enrolled.

How Long COBRA Coverage Lasts

COBRA coverage is a *temporary* continuation of coverage. When the qualifying event is loss of coverage due to the end of your employment or a change in your job status, COBRA coverage continues only up to a total of 18 months for you, your spouse/domestic partner and your children. However, when the qualifying event is your death, divorce, dissolution of a domestic partnership or a covered child's losing eligibility as a dependent, COBRA coverage for your qualified dependents may continue for up to a total of 36 months.

Additional Qualifying Events

The 18-month period of COBRA coverage can be extended as the result of:

- a disability; or
- a second qualifying event.

Special Rules for Disability

An 11-month extension of COBRA coverage may be available if any qualified beneficiaries under your county health care plan are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of COBRA coverage, and you must provide WageWorks with written notice and a copy of the SSA award letter within 60 days of the SSA determination and before the end of the first 18 months of COBRA coverage.

All qualified beneficiaries who have elected COBRA coverage will be entitled to the 11-month disability extension as long as the disabled qualified beneficiary is determined to be disabled. If the SSA determines that the disabled beneficiary is no longer disabled, you must notify WageWorks in writing of that fact within 30 days of the SSA determination.

DISABILITY EXTENSION UNDER KINGCARE℠

Under KingCare℠, if you or a covered dependent is totally disabled and coverage ends for any reason other than plan termination, medical coverage *only* for the disabling condition may be extended for 12 months at no cost. The disabled person may choose either the medical extension coverage under KingCare℠ or COBRA coverage; however, electing the extension means forfeiting the right to elect COBRA coverage and to convert to an individual policy. Other covered dependents may be able to elect coverage through COBRA.

Medical extension coverage will end when you or your covered dependents experience any of the following:

- are no longer disabled;
- become eligible for benefits under another group policy;

- reach the end of the 12-month extension; or
- your group plan ends.

Second Qualifying Event

If you or a covered dependent experiences another qualifying event while receiving 18 or 29 months of COBRA coverage, your spouse/domestic partner and covered children may receive additional months of COBRA coverage, up to a maximum of 36 months from the date that COBRA coverage began. To receive this extension, you must inform WageWorks of the qualifying event. This extension may be available to your spouse/domestic partner and covered children receiving COBRA coverage when:

- you die, divorce or end a domestic partnership; or
- a covered child is no longer eligible for coverage.

However, the extension is available only if the event would have caused your spouse/domestic partner or covered child to lose coverage under the plan if the first qualifying event had not occurred.

COBRA and Unpaid Leaves of Absence

You're eligible for COBRA coverage if your medical coverage ends because:

- you're no longer receiving coverage through federal, state or county job-protected family and medical leave;
- you're on workers' compensation for an injury, are no longer receiving coverage through federal or county job-protected family and medical leave, and are no longer receiving a payroll check from the county; or
- you're on an unpaid leave of absence.

As long as your payroll or human resources representative has informed Benefits, Payroll and Retirement Operations of your leave of absence, Benefits, Payroll and Retirement Operations will contact you about your COBRA rights. If you're on an unpaid leave of absence for 31 or more days and haven't received a COBRA enrollment packet, contact Benefits, Payroll and Retirement Operations immediately.

COBRA and Medicare

If you are enrolled in Medicare and experience a qualifying event that causes you to lose that Medicare coverage, you and your qualifying dependents will become eligible for COBRA coverage. If you became entitled to Medicare benefits less than 18 months before your termination or reduction of hours, COBRA coverage for your qualified dependents who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement.

If you enroll in COBRA coverage before you are entitled to Medicare, you will lose your COBRA coverage when you enroll in Medicare (you typically enroll in Medicare when you apply for Social Security benefits).

WageWorks will notify you and your qualified dependents of your options by sending a COBRA enrollment packet. You may apply for Medicare supplemental insurance for yourself through WageWorks. The supplemental insurance is provided through the PacifiCare Secure Horizons plan within specific counties. To qualify, you must contact WageWorks and apply within 30 days after the loss of your county coverage.

When You Can Make Changes Under COBRA

As long as you notify WageWorks, you may:

- discontinue county medical coverage at any time, and retain your county dental and vision coverage (WageWorks must receive your notification one month before you want the change to become effective);
- discontinue county dental and vision coverage at any time, and retain county medical coverage (WageWorks must receive your notification one month before you want the change to become effective);
- discontinue coverage for yourself and your dependents at any time (WageWorks must receive your notification one month before you want the change to become effective);
- add eligible dependents to your health care coverage when a qualifying life event occurs;
- change medical plans and out-of-pocket expense level/related premium you want during annual open enrollment; and
- change medical plans and out-of-pocket expense level/related premium you want between annual open enrollments if:
  - you have a change in family status;
  - you move out of your current plan's coverage area and another county plan offers coverage in your new location.

When COBRA Coverage Ends

COBRA coverage will be terminated before the end of the maximum period of your coverage if:

- any required premium isn't paid on time;
- a qualified beneficiary enrolls in Medicare (COBRA coverage may continue through the end of the original COBRA period for other family members, independent of the qualified beneficiary's enrollment in Medicare);
- the county no longer provides any group health care plan for its employees;
- the plan would terminate coverage of a participant or qualified beneficiary not receiving continued coverage for any reason (such as fraud); and
- the plan terminates (whether by contract or county bankruptcy).

If you die while on COBRA, your death is considered a second qualifying event and your covered family members may extend their COBRA coverage up to 36 months from the date of your death.

If you're interested in learning about your right to convert to an individual policy when your COBRA coverage ends, contact your health care plan (for example, KingCare℠ or Group Health) or the Statewide Health Insurance Benefits Advisors (SHIBA) for more information.

How to Contact the COBRA Administrator

You may obtain more information regarding your rights to COBRA coverage from WageWorks or Benefits, Payroll and Retirement Operations.

For more information about COBRA, HIPAA and other laws affecting group health care plans, you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration. Addresses and phone numbers for the nearest regional or district offices are available at www.dol.gov/ebsa.

To protect your family's rights, you should keep the county and WageWorks informed of any changes in the addresses of your covered dependents. You should also keep copies for your records of any address change notices you send to the county or WageWorks.

CONTINUING COVERAGE WHEN YOU RETIRE

Retiree medical benefits are an alternative to COBRA. When you retire, you can continue your health care coverage through COBRA or your county retiree medical benefits. You may choose one or the other. **Once you make an election, you may not change it.** In addition:

- if you elect to continue health care coverage through your county retiree medical benefits, you forfeit your rights to elect COBRA later on; and
- if you elect COBRA, you forfeit your rights to elect retiree medical benefits later on.

This section explains retiree medical benefits and how they differ from COBRA.

DEFINITION OF RETIREMENT

To be considered a King County "retiree" an employee must meet all service criteria, as outlined in King County Code. "Retire as a result of length of service" means an employee who is eligible, applies for and begins drawing a pension benefit from the State of Washington or the City of Seattle pension plan.

How Retiree Medical Benefits and COBRA Compare

Consider these differences when choosing between retiree medical benefits and COBRA benefits when you retire:

Comparison of Retiree Medical Benefits and COBRA

	Retiree Medical Benefits	COBRA
Health care coverage available	Continuation of your county medical and vision coverage Opportunity to elect a different retiree dental plan offered through Delta Dental of Washington	Continuation of your county medical, dental and vision coverage
Length of time coverage is available	Medical and vision—until you become eligible for Medicare Retiree dental plan—no time limit	Up to 18 months (29 months if you leave employment because of a disability as determined by Social Security)
Allowed to change medical plans between annual open enrollments	Yes	Yes

ADDITIONAL OPTIONS YOU CAN CONSIDER

You can also continue coverage through private insurance, the Washington Health Benefit Exchange and through Medicare. For information about private insurance, you'll need to contact the insurance companies directly or ask the Statewide Health Insurance Benefits Advisors (SHIBA) for assistance. For information about Medicare, contact Medicare.

Comparison of Retiree Medical Benefits and COBRA		
Eligibility	You must: • be covered under a county health care plan and lose county coverage because of retirement; • have worked at least five consecutive years at King County before retirement; • not be eligible for Medicare; • not be covered under another medical group plan; and • meet the requirements for formal service or disability retirement.	You must be covered under a county health care plan and lose county coverage for a qualifying reason (retirement is a qualifying reason)
Enrollment	Same requirements and time periods	

Who's Eligible for Retiree Medical Benefits

County-paid coverage ends the last day of the month you retire. You may pay to continue county medical and vision coverage and elect a different retiree dental plan offered through Delta Dental of Washington if you:

- have county benefits on your last day of employment;
- have worked for King County for at least a cumulative of five years before you retire;
- aren't eligible for Medicare (if you're Medicare-eligible, you may not continue medical and vision coverage, but you may purchase the retiree dental plan when you retire);
- aren't covered under another medical group plan; and
- meet the requirements for formal service or disability retirement under a Washington State Department of Retirement Systems pension plan or the Seattle City Employees' Retirement System plan (which applies only if you elected to remain under the City of Seattle system according to a formal agreement between King County and the City of Seattle).

However, there is an exception. You're **not** eligible to participate in retiree medical benefits if:

- you've opted out of your own coverage in order to be covered under your spouse/domestic partner's county coverage; and
- you retire before your spouse/domestic partner does.

Your county health care coverage must be in your name at the time you retire for you to be eligible for retiree medical benefits. However, you may continue coverage under your spouse/domestic partner's county health care benefits.

If you choose to continue coverage under your spouse/domestic partner's county health care benefits, at the time of your retirement, you must WageWorks, the county's retiree medical benefit administrator, that you're deferring your enrollment in retiree medical benefits until your spouse/domestic partner is no longer covered under the county plan.

Covered dependents are eligible for continued coverage under your retiree medical benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee.

Retiree medical benefits don't include life insurance, accidental death and dismemberment (AD&D) insurance and long-term disability (LTD) insurance coverage.

If you're participating in a health care flexible spending account (FSA) when you become eligible for retiree medical benefits, you may continue participating through the end of the calendar year.

How to Enroll in Retiree Medical Benefits

Your retirement is reported to Benefits, Payroll and Retirement Operations through your Termination Notice, which you need to complete, or through the payroll report.

Benefits, Payroll and Retirement Operations confirms your retirement status and notifies WageWorks, who contacts you regarding benefit plan options.

You'll need to elect retiree medical benefits within 60 days after your coverage ends or within 60 days from the date of the WageWorks letter notifying you of your options, whichever occurs later. If you elect retiree medical benefits, you must make the initial premium payment within 45 days of your election. **If you don't make the initial premium payment within those 45 days, your coverage will be terminated.** To expedite retiree medical coverage so your claims may be paid sooner, you may attach your initial payment to the election form and return them both to WageWorks.

All other premiums are due on the first of the month. Coverage automatically ends if payment isn't made within 30 days. WageWorks will provide you with more detailed payment information when it first contacts you.

Because retiree medical benefits take effect on the first day after your county coverage ends, there's no lapse in coverage—self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

What Your Coverage Options Are

If you elect retiree medical benefits, you pay to continue the health care coverage you had on your last day of employment. Your options include any combination of:

- medical coverage;
- dental coverage (as a different retiree dental plan);
- vision coverage; or

You may elect a different medical plan than you had on your last day of employment, and you may elect the out-of-pocket expense level and related premium you want. If you add dependents to your coverage, they receive the same coverage you elect for yourself.

The dental plan available to you is the King County Retiree Dental Plan, offered through Delta Dental of Washington. Unlike your other retiree medical benefits, you can continue these retiree dental benefits when you become eligible for Medicare. You must elect the retiree dental plan when you enroll in retiree medical benefits—you cannot enroll later on. If you choose to discontinue your retiree dental plan after you've elected it, you won't be able to sign up again. (For more information about the retiree dental plan and its cost, contact Benefits, Payroll and Retirement Operations).

When you elect retiree medical benefits, you waive your COBRA rights, but you may continue covering the same eligible dependents who were covered on the last day of your employment. If you don't continue covering the same eligible dependents, they have their own COBRA rights. If you continue covering the same eligible dependents under your retiree medical benefits and they cease to be eligible for retiree medical benefits, they'll have COBRA rights only if there is a qualifying event.

How to Make Changes Under Retiree Medical Benefits

If you notify WageWorks, you may:

- drop medical coverage and retain vision coverage anytime (WageWorks must receive notice one month before you want the change to take effect);
- drop vision coverage and retain medical coverage anytime (WageWorks must receive notice one month before you want the change to take effect);
- drop coverage for yourself and your dependents (WageWorks must receive notice one month before you want the change to take effect);
- add newly-eligible dependents to your health care coverage;
- change medical plans and out-of-pocket expense level/related premium you want during annual open enrollment; and
- change medical plans and out-of-pocket expense level/related premium you want between annual open enrollments if:
  - you add an eligible dependent;
  - you have a qualifying life event or a covered dependent exhausts the lifetime maximum of your medical plan; or
  - you move out of your current plan's coverage area and another county plan offers coverage in your new location.

When Retiree Medical Benefits End

Retiree medical benefits end:

- on the last day of the month you fail to make the required payments (payments must be made within 30 days of the due date);
- when you become entitled to Medicare after electing retiree medical benefits (your Medicare coverage begins on the first of the month in which you turn 65); or
- on the day the plan terminates, you die or you first become covered under another group health care plan after the date of your retiree medical benefit election.

When you're no longer covered under retiree medical, you may be entitled to purchase an individual conversion policy. An individual conversion policy usually provides different coverage from your county group coverage; some benefits you have now may not be available. A conversion policy may also cost more than your current coverage.

If you're interested in learning about your right to convert to an individual policy when your retiree medical coverage ends, contact your health care plan (for example, KingCare℠ or Group Health) or the Statewide Health Insurance Benefits Advisors (SHIBA) for more information.

If You Return to Work

Your Washington State Department of Retirement Systems (DRS) plan may allow you to return to work at King County while you're drawing your pension benefits during retirement. Because certain restrictions apply, contact DRS before returning to work.

If you return from retirement to work in a benefit-eligible position, you'll receive the same coverage that a regular employee in the same position receives. During this return-to-work period, the premiums you pay for retiree medical benefits are suspended. When the work period ends, you can resume your retiree medical benefits, as long as you're not Medicare-eligible.

Anytime you fail to meet eligibility requirements for benefits or when you leave post-retirement employment, you resume paying the full cost of your retiree medical benefits.

You must contact WageWorks to resume your retiree medical benefits.

If You Lose Eligibility Because You're Medicare-Eligible

If you elect retiree medical benefits for yourself and your qualified dependents before you're Medicare-eligible, retiree medical benefits end for everyone once you become Medicare-eligible. When this occurs:

- your Medicare coverage typically begins on the first of the month in which you turn 65 if you enroll in a timely fashion;
- you may apply for Medicare supplemental insurance for yourself through WageWorks (the supplemental insurance is provided through the PacifiCare Secure Horizons plan within specific counties; to qualify, you must contact WageWorks and apply within 30 days after your retiree medical benefits end);

- your qualified dependents may be eligible to continue their county coverage under COBRA for up to 36 months from the date coverage is lost because of your entitlement to Medicare (WageWorks will notify your qualified dependents of this option by sending a COBRA enrollment packet); and
- you and your qualified dependents may continue the retiree dental plan you elected when you were first eligible.

If you retire once you become Medicare-eligible or afterward, you and your covered dependents won't be eligible for retiree medical benefits. However:

- you may apply for Medicare supplemental insurance for yourself through WageWorks, as described above;
- your qualified dependents may continue county benefits under COBRA for up to 18 months from your loss of coverage due to retirement or for up to 36 months from the earlier Medicare entitlement date if you enrolled in Medicare less than 18 months prior to your retirement; and
- you can elect the retiree dental plan for you and your qualified dependents.

Depending on the date you retire and the date you become Medicare-eligible, COBRA may provide a longer period of continuation coverage for qualified dependents than retiree medical benefits provide. For more information, contact Benefits, Payroll and Retirement Operations.

For information on Medicare supplemental insurance options, contact the Statewide Health Insurance Benefits Advisors (SHIBA).

Health Care Glossary

Annual deductible

An "annual deductible" is the amount you pay each calendar year before the plan (other than Group Health) pays benefits. The annual deductible doesn't apply to any out-of-pocket maximums.

Annual open enrollment

An "annual open enrollment" is the annual period when benefit-eligible employees may join a plan, change plans, add or increase accidental death and dismemberment (AD&D) insurance coverage, and add eligible dependents for coverage within the limits of each benefit plan. The annual open enrollment also gives benefit-eligible employees the opportunity to enroll or re-enroll in a flexible spending account (FSA).

Chemical dependency

"Chemical dependency" is a psychological and/or physical dependence on alcohol or a state-controlled substance. The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered, or social or economic function is substantially disrupted.

COBRA

"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1986. COBRA allows plan members to continue health care coverage on a self-pay basis under certain circumstances for a limited time. The county offers all required COBRA rights to employees, their spouses/domestic partners and their children covered at the time coverage is lost.

Custodial or convalescent care

"Custodial or convalescent care" is care that primarily assists the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the participant to walk, get in and out of bed, bathe, get dressed, eat or prepare special diets or take medication that is normally self-administered.

Custodial parent

A "custodial parent" is the parent awarded custody of a child by a court decree. In the absence of a court decree, a custodial parent is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation. If the child resides with a third party for part of the year, the parent with whom the child resides the majority of nights is the custodial parent.

DESI drugs

"DESI (Drug Efficacy Study Implementation) drugs" are drugs that lack substantial evidence of effectiveness according to the FDA; but since they've been used and accepted for many years without significant safety problems, they continue to be used today. Examples include Donnatal, Naldec Syrup and Tigan suppositories.

Disability—Medical Plans

A "disability" is a condition determined to be disabling by the Social Security Administration, Washington State Department of Retirement Systems or the county-sponsored long-term disability plan.

Durable medical equipment

"Durable medical equipment" is mechanical equipment that:

- is prescribed by a physician;
- can stand repeated use and multiple users;
- is primarily and customarily used to serve a medical purpose; and
- is generally not useful to a person in the absence of illness or injury.

Emergency—Medical Plans

An "emergency" is the sudden, unexpected onset of a medical condition that threatens loss of life or limb, or may cause serious harm to the patient's health if not treated immediately.

Evidence of Insurability (EOI)

"Evidence of insurability (EOI)" is any statement or proof of a person's physical condition, occupation or other factor affecting his/her acceptance for insurance.

Experimental or investigational service/supply

An "experimental or investigational service/supply" is any treatment, procedure, facility, equipment, drug, drug usage, medical device or supply that meets any of the following criteria at the time it is or will be provided to the plan member:

- if a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-reviewed medical literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:
  - peer-reviewed medical literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.
  - standard reference compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

- the scientific evidence must permit conclusions concerning the effect of the health intervention on health outcomes, which include the disease process, injury or illness, length of life, ability to function and quality of life.
- the health intervention must improve net health outcome.
- the scientific evidence must show that the health intervention is as beneficial as any established alternatives.

The improvement must be attainable outside the laboratory or clinical research setting.

FMLA

"FMLA" stands for the Family and Medical Leave Act of 1993. FMLA allows you to take up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons if you meet eligibility requirements and up to 26 weeks of unpaid, job-protected leave to take care of a member of the armed services who was injured during active duty.

Formulary

A "formulary" is an authorized list of generic and brand-name prescription drugs approved for use by the FDA.

HIPAA

"HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

Lifetime maximum

A "lifetime maximum" is the maximum benefit amount you may receive from your medical plan or for a given benefit during your lifetime.

Limitations

"Limitations" are restricting conditions such as age, time covered and waiting periods, which affect the level of benefits.

Medically necessary

"Medically necessary" refers to health care services, supplies, treatments or settings considered appropriate and necessary according to generally accepted principles of good medical practice to diagnose or treat a medical condition. Services, supplies, treatments or settings must meet all of these requirements:

- are not solely for the convenience of the patient, his/her family or the provider of the services or supplies;
- are the most appropriate level of service or supply that can be safely provided to the patient;
- are for the diagnosis or treatment of an actual or existing illness or injury unless being provided for preventive services;
- are not for recreational, life-enhancing, relaxation or palliative therapy, except to treat terminal conditions;
- are not primarily for research and data accumulation;
- are appropriate and consistent with the diagnosis and, in accordance with accepted medical standards in the State of Washington, couldn't have been omitted without adversely affecting the patient's condition or the quality of health services rendered;

- as to inpatient care, couldn't have been received in a provider's office, the outpatient department of a hospital or a nonresidential facility without affecting the patient's condition or quality of health services; and
- are not experimental or investigational.

The plan member is responsible for the cost of services and supplies that aren't medically necessary.

KingCare℠ and Group Health reserve the right to determine whether a service, supply, treatment or setting is medically necessary. The fact that a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting doesn't, in itself, make it medically necessary.

Primary plan

A "primary plan" is a plan whose benefits for a covered person must be determined without taking the existence of any other plan into consideration.

Progressive medication management

"Progressive medication management" is a program for administering the use of medications so that the safest and most effective prescription drugs at the lowest cost are used, beginning with the use of generic drugs and progressing to the use of preferred and non-preferred drugs as medically necessary.

Qualified Medical Child Support Order (QMCSO)

A "Qualified Medical Child Support Order (QMCSO)" is a decree, judgment or order, including approval of a settlement agreement, from a state court or an administrative order that requires benefit plans to include a child in the employee's coverage and make any applicable payroll deductions.

Reasonable and customary (R&C) charges—KingCare℠

"Reasonable and customary (R&C) charges" are rates that are consistent with those normally charged by the provider for the same services or supplies and within the general range of charges by other providers in the same geographic area for the same services or supplies.

Secondary plan

A "secondary plan" is a plan whose benefits for a covered person must be determined by taking the existence of another plan into consideration.

Skilled nursing facility

A "skilled nursing facility" is a facility that provides room and board, as well as skilled nursing care, 24 hours a day and is accredited as an extended care facility or is Medicare-certified as a skilled nursing facility. It is not a hotel, motel or place for rest or domiciliary care for the aged.

Spinal Manipulation

"Spinal manipulation" is the manipulation of the spine to correct a subluxation (that is, incomplete or partial dislocation) identified on an X-ray. The subluxation must be consistent with the patient's neuromusculoskeletal symptoms, and treatment must be within the limits of a specific documented treatment plan. Services must be provided by a state-licensed chiropractor or osteopath. (Chiropractors are restricted by law to manipulation of the spine; osteopaths are licensed to perform manipulative therapy to all parts of the body.)

Temporomandibular joint (TMJ) disorders

"Temporomandibular joint (TMJ) disorders" are disorders affecting the temporomandibular joint (which is just ahead of the ear and connects the mandible, or jawbone, to the temporal bone of the skull) and exhibiting any of the following characteristics:

- pain in the musculature associated with the TMJ;
- internal derangements of the TMJ;
- arthritic problems with the TMJ; or
- abnormal range of motion or limited range of motion of the TMJ.

USERRA

"USERRA" stands for the Uniformed Services Employment and Reemployment Rights Act of 1994.

Usual, customary and reasonable (UCR) charges—Group Health

"Usual, customary and reasonable (UCR) charges" are the levels of benefits payable when expenses are incurred from an out-of-network provider. Expenses are considered usual, customary and reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies, and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies.

Flexible Spending Accounts

Flexible spending accounts (FSAs) allow you to set aside before-tax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA, you don't pay federal or Social Security (FICA) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

The county offers two FSAs for all benefit-eligible employees:

- health care FSAs, which allow you to set aside before-tax dollars to pay for certain expenses not covered by your medical, dental and vision plans—for example, copays for office visits and the cost of orthodontia not fully paid by your dental plan; and
- dependent care FSAs, which allow you to set aside before-tax dollars to pay for eligible dependent day care expenses for your child, disabled spouse or dependent parent while you and your spouse work or look for work.

Plan benefits are funded through employee before-tax salary reduction contributions, as permitted by Internal Revenue Code Section 125. The county pays the administrative expenses of the plan to the extent those expenses aren't paid from the plan.

Participating in FSAs

To effectively use your flexible spending accounts (FSAs), you need to know how they work. This section explains who is eligible, how and when to enroll, when participation begins and ends, and how certain life event changes affect your eligibility to participate in FSAs.

FSA PARTICIPATION INFORMATION ONLY

The information about eligibility and changing your coverage in this section applies to FSAs only.

For eligibility and participation information regarding the county's other benefits, see the separate descriptions of each benefit in this handbook.

Who Is Eligible

You're eligible to participate in an FSA when you become a benefit-eligible employee as:

- a regular part-time or full-time employee;
- a full-time Local 587 employee; or
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

You're not eligible to participate in an FSA if:

- you work less than half-time in a calendar year;
- you're a temporary or seasonal employee; or
- you work in a capacity that, at the discretion of human resources, is considered contract work or independent contracting;
- you receive medical benefits through the Affordable Care Act (ACA).

When and How to Enroll

You may enroll in an FSA when:

- you're first eligible for benefits;
- you experience a qualifying life event; or
- you make your benefit elections during an annual open enrollment.

When you enroll, you enroll for the calendar year (January 1–December 31). You must re-enroll each year during the county's annual open enrollment to continue participating the following year. If you don't enroll during the annual open enrollment, you won't be able to enroll after December 31 unless you have a qualifying life event.

Generally, you may not make changes until the next annual open enrollment period. However, you may have an additional opportunity to make changes if you have a qualifying life event.

IMPORTANT

When you enroll in an FSA, be careful to contribute only what you know you can use by the end of the calendar year— you're only allowed to carry over up to $500 in the Health Care FSA plan. What you don't use or carry over will be forfeited.

Enrolling When First Eligible

You receive FSA information and a Flexible Spending Account Enrollment form when you first become eligible for benefits.

You must return your enrollment form within 30 days of your benefit-eligibility date to Benefits, Payroll and Retirement Operations. Your benefit-eligibility date is the day you first report to work as a new employee or the date you meet the eligibility requirements of the plan, if later.

Enrolling During the Annual Open Enrollment

Each year, the county holds an open enrollment. During this period, you have the opportunity to enroll online for the first time or re-enroll in an FSA, and to determine your contribution amount for the upcoming calendar year. Elections made during the annual open enrollment take effect the following January 1 and remain in effect through December 31 of that calendar year.

You must re-enroll online every year if you want to participate in an FSA the next year.

Making Changes After a Qualifying Life Event

Because of the tax advantages available to you when you make FSA contributions on a before-tax basis, Internal Revenue Service (IRS) rules limit when you can enroll and change your contribution amount. That means the enrollment choices you make when you first become eligible or during an annual open enrollment are generally in effect for the entire year for which you enroll.

However, because your needs for benefits typically change when you experience certain "qualifying life events"—such as getting married or having a baby—you're allowed to make changes in some situations, in accordance with federal rules, as long as you make your changes within **30** days following the event.

Health Care Reimbursements After a Qualifying Life Event

If you increase your contribution to a health care FSA after a qualifying life event, there are certain restrictions on how your contributions can be reimbursed. You can use the amount you indicated as your annual contribution at the beginning of the year to pay for any allowable medical expenses throughout the year. However, expenses incurred before the qualifying life event can only be reimbursed by the amount you indicated as your annual contribution amount at the beginning of the year.

When Participation Begins

The date your FSA begins depends on when you enroll:

- if you enroll in an FSA when you first become eligible for benefits, your FSA begins on the day your benefits begin. You begin making contributions to your account by payroll deduction through the end of the calendar year. If you begin work on the first day of the month, your FSA begins that day. If you begin work on any other day of the month, your FSA begins on the first day of the following month.
- if you enroll in an FSA because of a qualifying life event, your FSA takes effect on the first of the month following your qualifying life event* and continues through the end of the calendar year. The amount you contribute to your account is adjusted for the remaining payroll periods in the calendar year.

*Newborn and adopted children are effective the first of the month in which the event occurs.

- when you enroll in an FSA online during the annual open enrollment, your FSA begins on January 1 of the following year and continues through December 31 of that calendar year, during which time you make contributions to your account with every paycheck.

You may be reimbursed only for expenses incurred after your participation begins.

When Participation Ends

Your participation in an FSA ends on the last day of the month when you leave employment with the county unless you continue your FSA coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) or the retiree medical benefit.

However, when you take a leave of absence without pay and aren't contributing to your FSA through payroll deductions, your participation is suspended temporarily until you return to work in a paid status, at which time your participation is resumed.

An Overview of FSAs

When you choose to participate in an FSA, you decide how much you want to contribute through payroll deduction to either a health care or dependent care FSA, or both, and indicate the amount(s) on the:

- Flexible Spending Account Enrollment form you return to Benefits, Payroll and Retirement Operations when you're a newly benefit-eligible employee; or
- online form during the annual open enrollment period or when you have a qualifying life event.

When Benefits, Payroll and Retirement Operations receives your submitted information, it verifies your eligibility and transmits the information to Payroll Operations (so deductions can be taken from your paycheck) and to a third-party administrator (WageWorks). WageWorks sets up your FSA and administers it for the county.

As you incur eligible expenses, you submit a request for reimbursement, receipts and other required documentation to WageWorks, and WageWorks reimburses you from your account. You may submit reimbursement requests to WageWorks for eligible expenses incurred during the calendar year anytime through March 31 of the following year.

Tax Savings

Your FSA contributions are automatically deducted from your pay and deposited into your account in equal amounts throughout the year. Contributions are deducted before federal, Social Security (FICA) and, where applicable, state and local income taxes are withheld. In addition, your contributions aren't reported as income on your federal W-2 statement at the end of the year. As a result, an FSA enables you to lower your taxable income and pay less in taxes but may lower your overall Social Security earnings. Please check with your tax advisor for additional information.

Estimating Expenses

It is very important that you estimate your expenses as accurately as possible when deciding upon your contribution amounts for a health care FSA or a dependent care FSA, or both. Any unused funds in the dependent care FSA or funds in excess of $500 in the health care FSA will be forfeited.

Effective 1/1/14, IRS guidelines allowed health care FSA plans to provide the option of carrying over up to $500 of unused amounts remaining at year-end. Any carryover amounts must be used within the following calendar year.

How the Health Care FSA Works

The health care flexible spending account (FSA) gives you the opportunity to set aside money from your pay before tax contributions are withheld and then use those non-taxable funds to reimburse yourself for eligible health care expenses you and your eligible family members incur.

Making Contributions

HEALTH CARE AND DEPENDENT CARE FSAS DON'T MIX

Health care and dependent care FSAs are separate accounts. The funds you allocate for one cannot be used for the other, and you cannot transfer dollars between accounts.

There are two ways you can save money on your taxes when it comes to health care expenses. One is to set aside from $300 up to $2,550 in before-tax dollars to pay for certain eligible health care expenses from a health care FSA. The other is to take a federal income tax deduction for certain eligible health care expenses if they exceed 7.5% of your adjusted gross income. For most people, making contributions to a health care FSA makes the most sense, but you should consult a tax advisor to be sure.

Highly Compensated Employees

For plans subject to federal regulations, Internal Revenue Code rules define certain employees as "highly compensated"—that is, their annual salary is $120,000 or greater. Employees determined to be highly compensated may be subject to special rules that affect their FSA reimbursement benefits. If your reimbursement benefits are affected because you're determined to be highly compensated, you'll be notified.

If you're classified as a highly compensated employee as defined by the IRS, your contributions to the health care FSA may be limited, depending on the participation levels of employees who aren't classified as highly compensated. If employee participation doesn't reach certain federal benchmarks, your contributions may be restricted. The county reserves the right to make adjustments to highly compensated employee elections under the health care FSA necessary for the county to pass any required discrimination testing.

Midyear Enrollments

When you enroll in a health care FSA midyear as a newly benefit-eligible employee, you begin making contributions to your health care FSA through payroll deductions for the remainder of the calendar year. When you change your health care FSA as the result of a qualifying life event, the amount of your contribution to your account is adjusted for the remaining payroll periods in the calendar year.

Knowing What's Covered and What's Not

You may use a health care FSA to reimburse expenses for yourself and any dependent who qualifies for coverage under your benefit plans. However, the Internal Revenue Code doesn't allow you to use a health care FSA to reimburse expenses for a domestic partner and his/her children unless they live with you as members of your household and you provide more than half of their support during the calendar year of your FSA.

IMPORTANT!

The rules determining support of your domestic partner and domestic partner's children are complex. You may wish to refer to IRS Publication 17 or consult a tax advisor.

Covered Expenses

In general, any health care expense that would be deductible on your federal income tax return is eligible for reimbursement, as long as you don't take a tax deduction for the same expense and you're not reimbursed for it in any other way. However, expenses for insurance premiums and long-term care **aren't** eligible for FSA reimbursement, even though long-term care costs are tax-deductible.

Here is a brief summary of health care expenses that generally are eligible for reimbursement through the health care FSA, as long as they're properly documented:

- medical, dental and vision expenses that are not covered by a health plan;
- copays, coinsurance and deductibles;
- prescription drug out-of-pocket costs.

Expenses Not Covered

Here is a brief summary of health care expenses that aren't eligible for reimbursement through the health care FSA:

- health club programs, including fitness clubs and gyms;
- health insurance and long-term care premiums;
- over-the-counter drugs, except insulin;
- vitamins, supplements and remedies taken for general well-being.

FOR MORE INFORMATION

You can find more examples of eligible and ineligible expenses by visiting www.wageworks.com or referring to IRS Publication 502, Medical and Dental Expenses. Publication 502 is available on the IRS Web site, www.irs.gov. Publication 502 also may include references to medical savings accounts, or MSAs. MSAs aren't the same as FSAs.

If you're not sure whether an expense is eligible, consult a tax advisor or the FAQs (frequently asked questions) at www.WageWorks.com.

Filing a Claim

With a health care FSA, you may begin getting reimbursed from the FSA as soon as you incur eligible expenses after your participation begins during the FSA calendar year and your health care FSA reimbursement request has been received and approved. You don't have to wait until you have sufficient funds in your health care FSA before you can be reimbursed from it.

You're reimbursed for eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year. How eligible expenses are reimbursed from a health care FSA depends on the type of expense you have.

Expenses Partially Covered by Health Insurance

For expenses partially covered by health insurance, you file a claim with your health plan. When you receive your Explanation of Benefits (EOB), you see how much the plan paid and the remaining balance due. You then request reimbursement for the remaining balance.

Submit an online claim or mail, fax or email a completed WageWorks Reimbursement Request form together with the following:

- an invoice from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided; **or**
- an EOB from your health insurance provider that shows the specific type of service you received, the date and cost of the service, and any uninsured portion of the cost; **and**
- if necessary, because a service could be deemed cosmetic in nature, a signed Letter of Medical Need from your health care provider indicating that the service was medically necessary, accompanied by the invoice or EOB for the service.

Expenses Not Covered by Health Insurance

For expenses not covered by health insurance, complete the WageWorks Reimbursement Request form and attach your itemized receipt for the expenses. Receipts must show date of service, cost, service performed and provider of service. Canceled checks, credit card receipts or statements showing only "balance due" or "payment on account" cannot be accepted. Fax or mail the information to WageWorks.

Orthodontia Expenses

For orthodontia services, a lump-sum payment to an orthodontist is eligible for full reimbursement. To be reimbursed, you must provide documentation, such as a receipt of payment, claim form or payment coupon, and it must include the patient's name, provider's name, date of service and cost of service. An orthodontia worksheet is not required, but a copy of your contract is required. Monthly payments will be reimbursed based on the actual amount paid. Orthodontia payments may be reimbursed over multiple plan years.

If Reimbursement Is Denied

If your claim for reimbursement is denied, WageWorks will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond WageWorks's control require more time, the review period may be extended up to 15 days, and you'll be notified of the extension before the initial 30-day period ends.

How the Dependent Care FSA Works

The dependent care flexible spending account (FSA) gives you the opportunity to set aside money from your pay before tax contributions are withheld and then use those non-taxable funds to reimburse yourself for eligible dependent care expenses you and eligible family members incur.

To receive reimbursements from a dependent care FSA, you must work full-time or part-time while your child (or children), disabled spouse or other disabled dependents (for example, a disabled parent) receive dependent care services. You also must meet one of the following eligibility requirements:

- you're a single parent;
- you have a working spouse;
- your spouse is a full-time student at least five months during the calendar year while you're working;
- your spouse is mentally or physically unable to care for himself/herself; or
- you're divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

Making Contributions

The minimum contribution you may make to a dependent care FSA is $300 per calendar year. The maximum contribution depends on your family situation, but that amount may not exceed $5,500 (or $2,500 if you are married and filing separate income tax returns).

Alternatively, you may take an income tax credit for your dependent care expenses of up to $3,000 per calendar year for one dependent or up to $6,000 per calendar year for two or more dependents.

To determine whether the dependent care FSA or the federal tax credit, or a combination of both, is best for you, consult a tax advisor.

When you enroll in a dependent care FSA during an annual open enrollment, you begin making contributions to your account:

- twice a month through payroll deduction over the next calendar year if you are paid on the 5th and 20th of the month; or
- every paycheck through payroll deduction over the next calendar year if you're paid every other week.

For example, if you're paid on the 5th and 20th of the month, the amount deducted is calculated by dividing your annual election by 24 pay periods. If you elected to contribute $4,500 to your FSA during the annual open enrollment, you would see a deduction of $187.50 per paycheck throughout the year.

Highly Compensated Employees

For plans subject to federal regulations, Internal Revenue Code rules define certain employees as "highly compensated"—that is, their annual salary is $120,000 or greater. Employees determined to be highly compensated may be subject to special rules that affect their FSA reimbursement benefits. If your reimbursement benefits are affected because you're determined to be highly compensated, you'll be notified.

If you're classified as a highly compensated employee as defined by the IRS, your contributions to the dependent care FSA may be limited, depending on the participation levels of employees who aren't classified as highly compensated. If employee participation doesn't reach certain federal benchmarks, your contributions may be restricted. The county reserves the right to make adjustments to highly compensated employee elections under the dependent care FSA necessary for the county to pass any required discrimination testing.

Midyear Enrollments

When you enroll in a dependent care FSA midyear as a newly benefit-eligible employee, you begin making contributions to your dependent care FSA through payroll deductions for the remainder of the calendar year. When you change your dependent care FSA as the result of a qualifying life event, the amount of your contribution to your account is adjusted for the remaining payroll periods in the calendar year.

The amount deducted is calculated by dividing your election by the number of remaining pay periods—for example, if you elected to contribute the $5,000 maximum to your dependent care FSA with 16 pay periods remaining in the calendar year, you would see a deduction of $312.50 per paycheck for the remainder of the year.

Knowing What's Covered and What's Not

You may use a dependent care FSA to pay for eligible dependent care expenses for your child (or children), disabled spouse or other disabled dependents, as defined below:

- a child under age 13 with whom you have a "specified relationship" and for whom you're entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, only the parent with whom the child resides for more than half of the calendar year can claim the child as an eligible dependent under the dependent care FSA;

- a disabled parent residing in your household for whom you provide a majority of support and who lives with you for more than half of the calendar year;
- your child of any age who is physically or mentally unable to care for himself/herself and who lives with you for more than half of the calendar year; and
- your spouse who is physically or mentally unable to care for himself/herself and who lives with you for more than half of the calendar year.

A qualifying "specified relationship" to the taxpayer for a child under 13 is defined as a son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister or a descendant of any such individual. Legally adopted children and foster children are considered to be children of the taxpayer.

Under the Working Families Tax Relief Act, you're not required to provide more than half of the cost of maintaining your household in order for your dependents to be eligible for dependent care FSA expenses.

Covered Expenses

Here is a list of dependent care expenses that are eligible for reimbursement through the dependent care FSA:

- care provided inside or outside your home by anyone other than you, your spouse, a person you list as your dependent for income tax purposes, or one of your children under age 19;
- a dependent care center or child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations);
- a housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent;
- deposits and registration fees;
- day camp tuition, including sports camps;
- preschool tuition, such as for a nursery school or day care center that provides meals and educational activities as part of its child care service; and
- adult care for a disabled spouse or parent. This includes only the day care expenses; nursing/medical care doesn't qualify for reimbursement through a dependent care FSA, but may qualify for reimbursement under a health care FSA.

To qualify for reimbursement, you must provide your dependent care provider's tax ID number, Social Security number or license number on your federal tax return. If you fail to do so, your dependent care FSA reimbursements may be reclassified as taxable income by the IRS. You must still complete IRS Form 2441 when reporting taxes at the end of each calendar year.

FOR MORE INFORMATION

Because the expenses that are eligible for reimbursement under the dependent care FSA are the same as those eligible for the federal tax credit, you can get additional examples of eligible expenses by referring to IRS Publication 503, Child and Dependent Care Expenses. Publication 503 is available on the IRS Web site, www.irs.gov.

If you're not sure whether an expense is eligible, consult a tax advisor or the FAQs (frequently asked questions) at www.WageWorks.com. You may also contact WageWorks.

Expenses Not Covered

Here is a list of dependent care expenses that aren't eligible for reimbursement through the dependent care FSA:

- books and supplies;
- child support payments or child care if you are a non-custodial parent;
- health care or educational tuition costs;
- services provided by your dependent, your spouse's dependent or your child who is under age 19; and
- overnight camps and education, including kindergarten (but summer day camps are eligible).

However, if the cost of tuition and dependent care can be separated, the itemized cost of the dependent care is reimbursable.

Filing a Claim

To get reimbursed from a dependent care FSA, complete WageWorks's Reimbursement Request form and attach any appropriate receipts or have the dependent care provider sign the claim form instead of a receipt. Submit an online claim, mail, fax or email the information to WageWorks.

If you submit a reimbursement request for an amount that is more than your FSA balance, you're reimbursed up to your current FSA balance. When future contributions are made to your FSA, you automatically receive another reimbursement until your total claim amount has been reimbursed or you reach your election amount for the calendar year.

If Reimbursement Is Denied

If your claim for reimbursement is denied, WageWorks will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond WageWorks's control require more time, the review period may be extended up to 15 days, and you'll be notified of the extension before the initial 30-day period ends. (For information about appeals, see "Flexible Spending Accounts" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information.*)

GLOSSARY

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 gives plan members the ability to continue health care coverage after leaving employment.

Federal tax credit

A federal tax credit is given to an individual or business as credit for a payment already made toward taxes owed.

Long-Term Disability Plan

King County hopes you'll never have to face a debilitating illness or injury; but if you do, the county's long-term disability (LTD) insurance plan is there to help safeguard your income and offer support to you and your family when illness or injury prevents you from working.

As a benefit-eligible employee, you receive county-paid basic long-term disability (LTD) insurance through CIGNA Group Insurance, as well as the option to purchase CIGNA supplemental LTD insurance for yourself when you first become a benefit-eligible employee with the county.

PARTICIPATING IN THE LTD PLAN

To effectively use the LTD plan, you need to know how it works. This section explains who is eligible to participate in the LTD plan, how and when to enroll, when you can make changes, what coverage costs and when coverage begins and ends.

LTD PARTICIPATION ONLY

The information about eligibility and changing coverage in this section applies to the county's LTD insurance coverage only. For eligibility and participation regarding other benefits, see the separate descriptions of each benefit in this guide.

Who Is Eligible

You're eligible for county-paid basic LTD insurance if you're:

- a regular part-time or full-time employee;
- a full-time Local 587 employee;
- an employee in a provisional, probationary or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible);
- an elected Union Officer of Amalgamated Transit Union Local 587;
- a Law Library Staff; or
- a non-union employee of Technical Employees Association (TEA) regularly working more than an employer-approved half-time schedule.

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

You're not eligible for basic or supplemental LTD insurance if:

- you work less than half-time in a calendar year;
- you're a temporary or seasonal employee; or
- you work in a capacity that, at the discretion of human resources, is considered contract work or independent contracting.

When you become a benefit-eligible employee (usually when you first come to work for the county), you're also eligible to purchase supplemental LTD insurance for yourself.

None of your dependents are eligible for the county's LTD insurance.

How and When to Enroll

While you automatically receive basic LTD insurance, there are limited opportunities to purchase supplemental LTD insurance.

Enrolling When First Eligible

When you become eligible for benefits, you receive benefit information and enrollment forms in a Regular Employee New Hire Guide at your new employee orientation. You're automatically enrolled in the basic LTD plan.

However, if you want to purchase supplemental LTD insurance, you must return your benefit enrollment forms to Benefits, Payroll and Retirement Operations within 30 days of your hire date. If your hire date, which is the first day you report to work, is the first day of the month, your benefits begin that day. If your hire date is any other day of the month, your benefits begin on the first day of the following month.

If you don't purchase supplemental LTD insurance when you're first eligible, you won't have the opportunity to do so again unless:

- the county opens supplemental LTD enrollment to all regular employees during the annual open enrollment; or
- you leave county employment and return to a benefit-eligible county position.

Enrolling During the Annual Open Enrollment

You can't purchase supplemental LTD insurance during the annual open enrollment unless the county offers the option to purchase supplemental LTD insurance to all regular employees.

When and How to Name a Beneficiary

Because you automatically receive basic LTD insurance when you first become benefit-eligible, and even if you don't elect supplemental LTD insurance, you may want to name one or more beneficiaries to receive your survivor benefit in the event of your death.

You may change your beneficiaries at any time by completing the CIGNA Beneficiary Designation form and mailing it to CIGNA.

Benefits are paid according to the most recently signed form on file. If no beneficiary is listed, your survivor benefit will be paid to your surviving spouse, or if your spouse is not living, in equal shares to your eligible children up to age 25, or if no children are living, to your estate.

When and How to Make Changes

You'll have limited opportunities to make changes to your LTD insurance.

Changes You May Make After Qualifying Life Events

"Qualifying life events" allow you to make midyear changes to your LTD coverage that you normally wouldn't be allowed to make. See the *Health Care Overview* section for a complete list. The only change you can make to your supplemental LTD insurance after a qualifying life event is to discontinue it.

Changes You May Make at Any Time

The only change you can make at any time is to discontinue your supplemental LTD insurance. That's because supplemental LTD insurance is optional, and you're paying the full cost of coverage.

Change Forms

If you want to discontinue your supplemental LTD insurance, you need to submit a written request to Benefits, Payroll and Retirement Operations or e-mail a request to kc.benefits@kingcounty.gov.

What Coverage Costs

Because you're a regular employee, your basic LTD insurance is paid by the county unless you're on an unpaid leave. In that case, you must pay the full cost of basic LTD insurance if you want to avoid a lapse in coverage.

If you elect supplemental LTD insurance, you pay a monthly premium. Your premium is based on your covered earnings of up to a maximum of $12,000 a month. You pay your monthly premiums through payroll deduction.

The cost of supplemental LTD insurance depends on your base annual salary. The rate for supplemental LTD insurance is $0.264 per $100 of salary.

When Coverage Begins

Coverage begins on the first day of the month following your hire date, which is the first day you report to work, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

If you happen to be ill or injured and away from work the day coverage begins, your LTD insurance will become effective the day you return to work on a regular schedule.

When Coverage Ends

Your LTD insurance ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the LTD plan terminates.

How to Convert Coverage

If you leave county employment and have been covered under the LTD plan and actively at work for at least 12 consecutive months, you may be eligible to purchase LTD conversion insurance with CIGNA. Benefits will differ from the county plan's benefits. You must apply for conversion insurance within 62 days after your county insurance ends.

Conversion insurance with CIGNA isn't available if:

- you're retired;

- you're 70 years of age or older;
- you're not in active service because of your disability; or
- the county policy is cancelled for any reason.

For information about converting your coverage, contact CIGNA.

THE LTD PLAN

The LTD plan pays you a portion of your income when you're unable to work because of a disability. To make the most of your LTD plan, you need to know some important things about it.

How the LTD Plan Works

Here's an overview of how LTD insurance works:

- if you become disabled on or off the job and meet the definition of "disabled," LTD benefits begin after the benefit waiting period ends. The "benefit waiting period" is the continuous time you must be disabled before LTD benefits begin.
- if you work reduced hours (less than the hours necessary to earn more than 80% of your indexed covered earnings) and meet the definition of "disabled," your LTD benefits subsidize your reduced earnings.
- the LTD plan pays monthly benefits until age 65 as long as you continue to meet the plan's definition of "disabled." The actual duration depends on when the disability begins—if your disability begins after you reach age 62, your maximum benefit period depends on your age.
- separate periods of disability due to the same or related causes are considered continuous unless you return to work for more than six consecutive months. Separate periods of disability due to unrelated causes or that occur after your plan coverage ends aren't considered continuous.
- benefits may be limited to 24 months for a disability caused by a mental disorder, drug abuse or alcohol abuse.
- if you become disabled, you also may be eligible to receive benefits from a number of other sources, such as Social Security disability and workers' compensation. In that case, your LTD benefits are reduced by the amount you receive or are eligible to receive from these other sources.
- any benefits you receive from an individual disability insurance policy don't reduce the benefits you receive from your county LTD insurance.
- if you die while receiving LTD benefits, your designated beneficiaries are eligible to receive a survivor benefit.

DEFINITION OF "DISABLED"

You're "disabled" if, because of injury or sickness:

- you're unable to perform all the material duties of your **regular occupation**, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings from working in your regular occupation; and
- after disability payments have been payable for 24 months, you're unable to perform all the material duties of **any occupation** for which you may reasonably become qualified based on education, training or experience, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings.

Basic LTD Insurance

Your basic LTD insurance provides up to a total of 60% of all your predisability earnings after a 180-day benefit waiting period. The "benefit waiting period" for basic LTD insurance is the continuous time you must be disabled before LTD benefits begin.

If you have income from other sources, such as workers' compensation or Social Security, that income is combined with your LTD benefit to cover the 60% of the predisability earnings you are entitled to receive under the plan while you're on disability. In other words, LTD insurance makes up the difference between other sources of income and the amount needed to ensure that you receive 60% of your predisability earnings while you're on disability.

If you return to work during your disability, your benefit amount can be as much as 100% of your predisability earnings.

Your predisability earnings are based on your work earnings in effect on your last full day of active work. The minimum monthly benefit is either $100 or 10% of your monthly benefit, whichever is greater. This minimum monthly benefit is paid even if your income from other sources equals more than 60% of your salary. The maximum monthly benefit you may receive from the basic LTD plan is $6,000.

PREDISABILITY EARNINGS

Predisability earnings exclude premium pay, bonuses, overtime pay or other extra compensation, and taxes. This amount is determined on the date coverage begins and changes on the date of any pay adjustment you receive if you're actively at work.

Supplemental LTD Insurance

Your supplemental LTD insurance provides up to a total of 60% of all your predisability earnings after a 90-day benefit waiting period. The "benefit waiting period" for supplemental LTD insurance is the continuous time you must be disabled before LTD benefits begin.

If you have income from other sources, such as workers' compensation or Social Security, that income is combined with your LTD benefit to cover the 60% of the predisability earnings you are entitled to receive under the plan while you're on disability. In other words, LTD insurance makes up the difference between other sources of income and the amount needed to ensure that you receive 60% of your predisability earnings while you're on disability.

If you return to work during your disability, your benefit amount can be as much as 100% of your predisability earnings.

Your predisability earnings are based on your work earnings in effect on your last full day of active work. The minimum monthly benefit is either $100 or 10% of your monthly benefit, whichever is greater. This minimum monthly benefit is paid even if your income from other sources equals more than 60% of your salary. If you elect the supplemental LTD insurance plan, your maximum monthly benefit from this plan is increased to $7,200.

Qualifying for Benefits

You become eligible for LTD benefits when you meet the plan's definition of "disabled." You're considered "disabled" if, solely due to injury or illness, you're unable to:

- perform all the material duties of your regular occupation; and
- earn more than 80% of your indexed covered earnings from working in your regular occupation.

After you've been receiving LTD benefits for 24 months, you're considered "disabled" if your injury or illness makes you unable to perform the material duties of **any** occupation for which you could reasonably become qualified (based on education, training or experience) and, solely due to injury or illness, you remain unable to earn more than 80% of your indexed covered earnings.

DETERMINING DISABILITY

CIGNA, not King County, determines whether you meet the definition of "disabled" for LTD benefits.

During your benefit waiting period or until CIGNA determines your eligibility for LTD benefits, whichever occurs later, you need to pay premiums for your basic and/or supplemental insurance so that your coverage does not lapse.

Calculating LTD Benefits

Your predisability earnings are based on your work earnings in effect on your last full day of active work. To estimate your LTD monthly benefit, use the following formula:

(predisability earnings × .60)	**–**	**other income benefits**	**=**	**your monthly total LTD benefit**

Your covered earnings on your last active day worked determines your predisability earnings.

LTD benefits are taxable unless you elect supplemental LTD. If you elect supplemental LTD, you receive 40% of your total benefit amount tax-free, and the remainder is taxable.

Covered Earnings

Your base monthly salary is your annual salary divided by 12, which excludes overtime pay, premium pay, bonuses and other extra compensation, and taxes.

Other Sources of Income

To determine the LTD benefit you receive, CIGNA will calculate your LTD benefit based on your work earnings on the last day you worked. The calculation will initially include other sources of income, such as workers' compensation, that you're receiving at that time. As you become eligible for other sources of income, such as Social Security and retirement income, your LTD benefits may be offset by your income from those other sources. The maximum LTD benefit you can receive is 60% of your work earnings on your last day of work.

Coordinating with Social Security

If you're disabled, you may be entitled to Social Security disability benefits. Because the amount of your LTD benefit is affected, in part, by your Social Security benefits, you must apply for Social Security and provide CIGNA with proof of your application before your LTD benefit is determined. However, CIGNA will not withhold your LTD benefit while your Social Security application is being processed.

Other Income Benefits

If you're disabled and eligible for LTD benefits, you should first apply for benefits from the income sources listed below that pertain to you:

- the Canada and Quebec Pension Plans;
- the Railroad Retirement Act;
- any local, state, provincial or federal government disability or retirement plan or law as it pertains to the county (however, you're not required to take early retirement benefits to receive your LTD benefits);
- any sick leave plan or other salary continuation plan of the county;

- any work loss provision in mandatory no-fault auto insurance;
- disability benefits under any workers' compensation, occupational disease, unemployment compensation law or similar federal, state or local government program, including all permanent and/or temporary disability benefits. This includes damages, compromises and settlements paid in place of such benefits, whether or not liability is admitted;
- any Social Security disability benefits you or a third party receives or is assumed to receive on your behalf or for your dependents or, if applicable, which your dependents receive or are assumed to receive because of your entitlement to Social Security benefits;
- any retirement plan benefits funded by the county (however, you're not required to take early retirement benefits to receive your LTD benefits);
- any proceeds payable under any franchise or group insurance or similar plan;
- any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise where a third party may be liable, regardless of whether liability is determined; and
- any wage or salary for work performed; if you're covered for the return-to-work incentive, CIGNA will reduce disability benefits only to the extent stated under the return-to-work incentive.

If you don't apply for benefits from the income sources listed above, CIGNA will estimate your benefits from these other sources and deduct it from your monthly LTD benefit.

When you or your dependents receive benefits from other income sources, CIGNA will notify you of the amount of any overpayment. You must repay CIGNA in full before receiving county LTD benefits.

Understanding Exclusions and Limitations

No LTD benefit is payable for a disability caused by or contributed to by:

- war or any act of war (declared or undeclared);
- revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless solely due to injury or illness otherwise covered by the LTD plan;
- terrorism or active participation in a riot; and/or
- committing a felony.

You must participate fully in any program or rehabilitative plan or modified work arrangement that CIGNA requires. LTD benefits aren't payable for any period of disability during which you:

- fail to cooperate with CIGNA in administering the claim (e.g., not providing any information or documents needed to determine whether benefits are payable or the actual benefit due);

- refuse to participate in rehabilitation efforts or in a transitional or other modified work arrangement; or
- aren't receiving appropriate care.

No LTD benefits are paid for any period of disability when you're not under the appropriate care of a licensed physician. Appropriate care is defined by an accurate and medically supported diagnosis by a licensed physician and a plan established by the physician for ongoing medical treatment and care of the disability which conforms to generally accepted medical standards, including frequency of treatment and care.

Mental Disorder or Drug/Alcohol Abuse

Payment of LTD benefits is limited to 24 months for a disability caused or contributed to by a mental disorder or drug/alcohol abuse. However, if you're confined in a hospital for more than 14 consecutive days before reaching the end of the 24 months, that period of confinement won't count against the 24-month lifetime limit. After 24 months, benefits won't be payable for any of the following conditions:

- alcoholism;
- anxiety disorders;
- delusional (paranoid) disorders;
- depressive disorders;
- drug addiction or abuse;
- eating disorders;
- mental illness; and
- somatoform disorders.

Preexisting Conditions

A "preexisting condition" is an injury or sickness for which, during the three months before your coverage begins, you:

- incurred expenses;
- received medical treatment, care or services, including diagnostic measures;
- took prescribed drugs or medications; or
- did not consult a physician when a reasonable person would have.

The preexisting condition limitation applies to any added benefits or increases in benefits. You won't receive LTD benefits for a disability caused or contributed to by a preexisting condition unless, on the day you become disabled, you've been in active service for at least 12 months after your most recent effective date of insurance or the effective date of any added or increased benefits.

Receiving Benefit Payments

You're eligible to receive LTD benefits if you:

- remain continuously disabled during the benefit waiting period;
- provide proof of continued disability; and
- have regular, continuing care by a licensed physician for the disabling condition.

You must pay the premium for your basic and/or supplemental LTD insurance during the benefit waiting period or until CIGNA determines your eligibility for LTD benefits, whichever is later.

After CIGNA receives and accepts proof of your disability, LTD benefits are paid monthly. If you're not disabled for a complete month after the benefit waiting period but you've had a loss of 20% or more in your work earnings, an amount equal to 1/30 of the LTD benefit is payable for each day that you're disabled.

Spouse Rehabilitation Benefit

While you're disabled, your spouse may be eligible to participate in a rehabilitation plan. At CIGNA's discretion, the rehabilitation plan may cover payment of your spouse's reasonable expenses for education, job placement and relocation. It may also cover family expenses necessary for your spouse to be retrained under the rehabilitation plan.

For your spouse to be eligible, the following conditions must be met:

- you must be continuously disabled for 12 months;
- your spouse's earnings must be 60% or less of your covered earnings; and
- your spouse must be determined by CIGNA to be a suitable candidate for rehabilitation.

Disability benefits will be reduced by 50% of your spouse's earnings from rehabilitative work. If your spouse is working before the rehabilitation plan begins, disability benefits will be reduced by 50% of the increase in income that results from your spouse's participation in the plan.

DEFINITION OF SPOUSE

"Spouse" means your lawful spouse living with you on the date your disability begins. The Rehabilitation Plan will end if your spouse is not living with you during the term of the agreement.

Survivor Benefit

If you die while receiving LTD benefits, a lump sum equal to three times your last net monthly benefit, plus any other earnings by which this benefit has been reduced, will be paid to your designated beneficiaries. This survivor benefit will first be applied to reduce any overpayment of your LTD claim.

If you haven't named a beneficiary, CIGNA will pay your surviving spouse. If there's no spouse, benefits will be paid in equal shares to your eligible children up to age 25. If you don't have a spouse or eligible children, CIGNA will pay your estate. Benefits aren't paid to a domestic partner unless he/she is specifically named as a beneficiary.

To update your beneficiary information for the survivor benefit, complete CIGNA's Beneficiary Designation Form, which is available online at the Benefits, Payroll and Retirement Web site. Mail the completed Beneficiary Designation Form directly to CIGNA.

DEFINITION OF CHILDREN

"Children" means your unmarried children under age 25 who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.

How to File a Claim

If you're disabled and it seems likely your disability will last for the duration of the benefit waiting period, contact CIGNA by phone or through its Web site. You can submit a paper claim form or an online claim form, or you may submit your claim by phone.

When you submit a claim, you need to provide:

- your group number, FLK-980001;
- your name, address, phone number, birth date, Social Security number and e-mail address (if applicable);
- the reason you're filing the claim (illness or injury) and whether you've filed or plan to file a workers' compensation claim;
- a description of your illness, injury, symptoms and/or diagnosis, including the date symptoms first appeared and whether you had the illness, injury or symptoms before;
- information regarding any visits you've made to a doctor, hospital or clinic for this claim, including health care provider names, addresses, and phone and fax numbers; and
- employment information (including hire date, job title and job description) and details on any benefits you're receiving from Social Security, unemployment, state disability or other sources.

You'll also need to contact your health care providers to give them permission to release your medical information to CIGNA. In response, CIGNA may send you or your attending physician (with your authorization) a request for more information. **No claim is payable until CIGNA approves it.**

To determine whether LTD benefits should be allowed or continued, CIGNA has the right, at its own expense, to have you examined at reasonable intervals by specialists of CIGNA's choosing. If an independent medical exam is requested, CIGNA pays for it. However, any cost for routine updates on your condition is your responsibility.

CIGNA processes your claim within 45 days of receipt. If CIGNA requires more time, you'll be notified in writing before the end of the initial 45 days of the need for an extension of up to 30 days. If your claim can't be processed during this initial 30-day extension, you'll be notified in writing that a second extension of up to 30 days is necessary.

When Benefit Payments Begin

Benefit payments for basic LTD insurance begin after a 180-day benefit waiting period. All payments are subject to federal income tax*. If you elected supplemental LTD insurance, benefit payments begin after a 90-day benefit waiting period. However, Social Security (FICA) is deducted from all LTD benefits paid between the 90-day and 180-day benefit waiting periods.

***Note**: If you elect supplemental LTD, you receive 40% of your total benefit amount tax-free, and the remainder is taxable.

How Long Benefit Payments Continue

Certain conditions may cause your LTD benefit payments to end. If your LTD benefits haven't ended, you may continue to receive benefit payments for up to a maximum benefit period as shown in the following chart:

If your disability begins at age...	Your maximum benefit period is...
62 or younger	To age 65 (or for 42 months, if longer)
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and older	12 months

When Benefit Payments End

Your monthly LTD benefit payments end on the earliest of:

- the date you're no longer disabled;
- the date you die;
- the date you don't provide proof of continued disability as requested;
- the date your disability earnings exceed 80% of indexed covered earnings;

- the date your disability due to a mental disorder or drug/alcohol abuse exceeds 24 months;
- the date you cease to be under the care of a licensed physician;
- the date you refuse to participate in rehabilitation services;
- the date you're no longer receiving appropriate care; or
- the date you reach your maximum benefit period.

If you end employment, disability payments don't end as long as you continue to be disabled. Benefits continue through your maximum benefit period.

Returning to Work

The LTD plan encourages you to return to work during your disability by offering the following incentives:

- if you work while disabled during the first 12 months that you're eligible for LTD benefits, you receive your LTD benefits plus your work earnings, up to 100% of your predisability earnings.
- if you work while disabled after the first 12 months, LTD benefits are reduced by 50% of your work earnings. If the sum of LTD benefits, work earnings and other income benefits exceeds 80% of indexed covered earnings, LTD benefits will be reduced by the excess amount.

Work earnings include any wage or salary for work performed while disability benefits are payable. If you're working for another employer on a regular basis when disability begins, work earnings will include any increase in the amount you earn from this work during the period for which disability earnings are payable.

GLOSSARY

Active service

An employee is considered to be in "active service" on a day considered a scheduled workday when either of the following conditions is met:

- he/she is actively at work performing his/her regular occupation on a full-time basis either at one the county's usual places of business or at a location to which the county's business requires him/her to travel; or
- the day is a scheduled holiday, vacation day or period of approved paid leave of absence.

An employee is considered to be in "active service" on a day not considered a scheduled workday only if he/she was in active service on the preceding scheduled workday.

Base monthly salary

Your "base monthly salary" is your annual salary divided by 12, which excludes overtime pay, bonuses and any other additional compensation.

Benefit waiting period

The "benefit waiting period" is the continuous time you must be disabled before LTD benefits begin.

Covered earnings

"Covered earnings" means your amount of pay prior to any premium pay, taxes, bonuses, overtime pay or other extra compensation, as reported by King County for work performed just before the date on which the disability begins.

CPI-W

"CPI-W" stands for the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another comparable nationally published index will be used.

Disability

You're "disabled" if, because of injury or sickness:

- you're unable to perform all the material duties of your **regular occupation**, and solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings from working in your regular occupation; and
- after disability payments have been payable for 24 months, you're unable to perform all the material duties of **any occupation** for which you may reasonably become qualified based on education, training or experience, and solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings.

Gross monthly benefit

"Gross monthly benefit" is your monthly LTD benefit before any reduction by other income benefits or taxes.

Indexed covered earnings

For the first 12 months that monthly LTD benefits are payable, "indexed covered earnings" will equal covered earnings. Afterward, indexed covered earnings will equal covered earnings plus an increase applied each anniversary of the date monthly LTD benefits became payable. The amount of each increase is whichever is less:

- 10% of the employee's indexed covered earnings during the preceding year of disability; or
- the rate of increase in the CPI-W during the preceding calendar year.

Predisability earnings

"Predisability earnings" excludes premium pay, bonuses, overtime pay or other extra compensation, and taxes. This amount is determined on the date coverage begins and changes on the date of any pay adjustment you receive if you're actively at work.

Preexisting condition

A "preexisting condition" is an injury or sickness for which, during the three months before your coverage began, you incurred expenses, received medical treatment or services, took prescribed drugs or medication, or didn't consult a physician when a reasonable person would have. The LTD plan doesn't pay benefits for preexisting conditions unless, on the date you become disabled, you're actively at work and have been in active service for at least 12 months following your most recent effective date of insurance or the effective date of any added or increased benefits.

Work earnings

"Work earnings" refers to your base monthly salary from work you perform while disabled and includes earnings from the county, another employer or self-employment. If you're working for another employer on a regular basis when your disability begins, your work earnings will include any increase in the amount you earn from this work during the period for which disability earnings are payable.

Life and Accident Protection

King County offers you and your family security and important financial support if you or a covered family member dies or is seriously injured in an accident. By offering both county-provided and supplemental life and accident benefits, the county gives you the flexibility to obtain the financial coverage that meets your personal needs.

As a benefit-eligible employee, you receive county-paid basic life insurance through Aetna Life Insurance and basic accidental death and dismemberment (AD&D) insurance through CIGNA Group Insurance. You also have the option to purchase supplemental life insurance and supplemental AD&D insurance for you and your eligible dependents.

Participating in the Life and Accident Plans

To effectively use your county life and accidental death and dismemberment (AD&D) insurance plans, you need to know how they work. This section about participation in the life and AD&D insurance plans explains who is eligible for life and AD&D insurance, when and how to enroll, when and how to make changes, what coverage costs, when coverage begins and ends, and how to continue or convert coverage.

LIFE AND ACCIDENT PROTECTION PARTICIPATION ONLY

The information about eligibility and changing coverage in this section applies to the county's life insurance and AD&D insurance plans only. For eligibility and participation regarding other benefits, see the separate descriptions of each benefit in this guide.

Who Is Eligible

You and your family members are eligible for life and AD&D insurance.

Employee

You're eligible for county-paid basic life and basic AD&D insurance if you're:

- a regular part-time or full-time employee;
- a full-time Local 587 employee;
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible); or
- an employee eligible for benefits through the provisions of the Affordable Care Act (ACA).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

You're not eligible for basic or supplemental life and basic or supplemental AD&D insurance if:

- you work less than half-time in a calendar year;
- you're a temporary or seasonal employee; or
- you work in a capacity that, at the discretion of human resources, is considered contract work or independent contracting.

At the time you become a benefit-eligible employee (usually when you first come to work for the county), you're also eligible to purchase supplemental life and supplemental AD&D insurance for yourself. You may be eligible to purchase supplemental life and supplemental AD&D insurance at other times as well.

If you go on active military leave while employed with the county, you're eligible to continue receiving county-paid basic life insurance for up to 12 months. You can also pay to continue any supplemental life and supplemental AD&D insurance you have for you and your covered dependents. However, you must convert any supplemental AD&D insurance after six months if you want to continue it.

Spouse/Domestic Partner

Your spouse/domestic partner is eligible for supplemental life insurance up to age 99 and eligible for supplemental AD&D insurance up to age 80, if you purchase supplemental life and supplemental AD&D insurance for yourself. If both you and your spouse/domestic partner work for the county, however, you may not cover each other under your supplemental life and supplemental AD&D insurance, unless one of you is a short-term temporary employee without benefits.

Your spouse/domestic partner in active full-time military service isn't eligible for supplemental life insurance. However, your spouse/domestic partner may continue coverage under supplemental AD&D insurance for off-duty injuries and accidents.

Children

Your children are eligible for supplemental life and supplemental AD&D insurance if you purchase supplemental life and supplemental AD&D insurance for yourself. If both you and your spouse/domestic partner work for the county, however, only one of you may cover your eligible children.

Eligible children include:

- your unmarried children or your spouse's/domestic partner's unmarried children up to age 26. "Children" or "child" means:
  - biological children;
  - adopted children, or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption;
  - stepchildren; and
  - legally designated wards, including legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan (For more information, see "Qualified Medical Child Support Order (QMCSO)" in "Participating in the Health Care Plans" in *Health Care*);

- a child (as defined above) age 26 or older if he/she:
  - was incapacitated and covered under your plan before age 26;
  - continues to be incapacitated due to a developmental or physical disability;
  - is incapable of self-sustaining employment; and
  - is dependent on you for more than 50% support and maintenance.

Disabled Dependent Children

If you want to continue coverage for a disabled child when he/she turns 26, you must submit a Continue Coverage for Disabled Adult Child form to Benefits, Payroll and Retirement Operations within 31 days of the child's 26th birthday. You also must provide proof of the child's continued disability annually thereafter.

When and How to Enroll

While you automatically receive basic life and basic AD&D insurance, you have limited opportunities to purchase supplemental life and supplemental AD&D insurance. It's important to know when and how to enroll.

Enrolling When First Eligible

When you become eligible for benefits, you receive benefit information and enrollment forms in a Regular Employee New Hire Guide at your new employee orientation. You're automatically enrolled in the basic life and basic AD&D plans.

If you want to purchase supplemental life and supplemental AD&D insurance for you and your eligible dependents, you must return your benefit enrollment forms to Benefits, Payroll and Retirement Operations within 30 days of your hire date. If your hire date, which is the first day you report to work, is the first day of the month, your supplemental coverage begins that day. If your hire date is any other day of the month, your supplemental coverage begins on the first day of the following month.

Supplemental Life Insurance

If you don't purchase supplemental life insurance when you first become eligible for coverage, you won't have the opportunity to purchase it again unless:

- you have a qualifying life event;
- you leave county employment and return to a benefit-eligible county position; or
- the county opens supplemental life insurance enrollment to all regular employees during the annual open enrollment.

Supplemental AD&D Insurance

If you don't purchase supplemental AD&D insurance when you first become eligible for coverage, you won't have the opportunity to purchase it again unless:

- you have a qualifying life event;
- you enroll in supplemental AD&D insurance during the annual open enrollment; or
- you leave county employment and return to a benefit-eligible county position.

Enrolling During the Annual Open Enrollment

During the annual open enrollment, you can decrease supplemental life insurance and purchase, increase, reduce or discontinue supplemental AD&D insurance. You cannot purchase or increase supplemental life insurance during the annual open enrollment unless the county opens the option to purchase and increase supplemental life insurance to all regular employees at that time.

When and How to Name a Beneficiary

Because you automatically receive basic life and basic AD&D insurance when you first become benefit-eligible, and even if you don't elect supplemental life and supplemental AD&D insurance, you need to name one or more beneficiaries to receive your benefit in the event of your death.

When you first enroll, you receive two beneficiary forms: an Aetna Life Insurance Designation of Beneficiary form for your life insurance, and a CIGNA Beneficiary Designation form for your AD&D insurance. You need to complete and mail these forms directly to Aetna for life insurance and to CIGNA for AD&D insurance. Copies of these forms are available from Benefits, Payroll and Retirement Operations and its Web site.

If you don't name a beneficiary, benefits are paid to your spouse first, then to your children in equal shares if your spouse does not survive you. If none of them survive you, benefits are paid to your estate.

You may change your beneficiaries at any time by completing the Aetna Life Insurance Designation of Beneficiary form and CIGNA Beneficiary Designation form, and mailing the forms to Aetna and CIGNA, respectively.

Benefits are paid according to the most recently signed form on file. If you elect supplemental life and/or supplemental AD&D insurance for your eligible dependents and a covered dependent dies, you are the beneficiary. Benefits for dismemberment, paralysis and other losses to you or your covered dependents are paid to you.

When and How to Make Changes

Because things change in life, you may want to make changes to your life and AD&D insurance. It's important to know when and how you can make changes.

Changes You May Make After Qualifying Life Events

When you have a qualifying life event, you may add, increase, decrease or discontinue supplemental life and supplemental AD&D insurance for you and your eligible dependents. However, to add supplemental life and supplemental AD&D insurance for your eligible dependents, you must already have the supplemental insurance for yourself or elect it for yourself first as a result of the qualifying life event.

If you experience a qualifying life event, you may elect or increase supplemental life insurance to the maximum of 4x your annual salary, not to exceed $400,000, without providing evidence of insurability (EOI). Covered spouses/domestic partners may elect supplemental life insurance up to $100,000 without evidence of insurability (EOI), and up to $200,000 with an approved evidence of insurability (EOI).

Increasing or adding supplemental AD&D insurance as the result of a qualifying life event has no similar restriction.

Changes You May Make at Any Time

The only change you can make at any time to supplemental life and supplemental AD&D insurance is to discontinue or decrease coverage—that's because you're paying for it.

Change Forms

To add or change life and AD&D insurance after a qualifying life event, you must complete the appropriate form online within 30 days after the qualifying life event.

If you wish to discontinue your supplemental life and/or supplemental AD&D insurance, you need to submit a written request to Benefits, Payroll and Retirement Operations or e-mail your request to kc.benefits@kingcounty.gov.

When Coverage Begins

Coverage begins on the first day of the month following your hire date, which is the first day you report to work, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

If you happen to be ill or injured and away from work on the date coverage begins, your life insurance will take effect when you return to work for one full day, and your AD&D insurance will take effect on the first day of the month following your return to work.

When Coverage Ends

Coverage ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the plan terminates.

Your covered dependent's life and AD&D insurance also ends on the last day of the month your covered dependent enters into active full-time military service.

How to Continue or Convert Coverage

When you leave county employment, you may want to know your options for continuing and/or converting your life and AD&D insurance coverage.

Life Insurance

When you leave county employment for reasons other than illness, you may continue your existing county life insurance, which is a group term insurance, or convert it to a whole life policy.

Continuing Group Term Life Insurance (For Reasons Other Than Illness)

Your county life insurance, which is group term insurance, is portable. That means that when you leave county employment and you are not ill or injured and away from work on the date your coverage ends, you may continue to pay Aetna directly for the basic and supplemental coverage you had on your last day of employment, up to $500,000, until you reach age 99. The age-specific rates you pay for the continued coverage may be different from the rates paid by active employees.

If you continue coverage, you may also continue the supplemental life insurance you had on your last day of employment for:

- your spouse/domestic partner until he/she is age 99, up to $100,000; and
- your dependent children until they're age 25, up to $5,000.

Employee or covered dependent life benefits in excess of the portability maximums may be converted to a whole life policy.

Coverage terminates when you reach age 99 or when you stop premium payments. Continued coverage for your spouse/domestic partner and children ends when they reach the limiting age or when your coverage ends. However, they may convert to an individual whole life insurance policy.

To continue coverage, you must request a Portability Application from Aetna and return the completed form with your first premium payment within 31 days after the date your county coverage ends. If you die during that 31-day period, your beneficiaries or estate will receive the full amount of your life insurance coverage in force before coverage ended. This payment is made under the group policy, whether or not you actually applied to continue coverage. If you applied, any fees or premiums you paid are refunded.

For information about continuing your life insurance coverage, contact Aetna.

Continuing Group Term Life Insurance When You're Disabled

You may be able to continue life insurance if you become disabled. You're considered permanently and totally disabled only if disease or injury stops you from working at your own job or any other job for pay or profit, and it continues to stop you from working at any reasonable job. A "reasonable job" is defined as any job for pay or profit that you are (or may reasonably become) fitted for by education, training or experience.

Converting to Individual Whole Life Insurance

You, your spouse/domestic partner and your children may apply to convert your county life insurance to an individual whole life insurance policy if you:

- leave county employment for any reason; or
- elect to continue your county life insurance when you leave county employment, but discontinue it or lose eligibility for it later.

To convert your county life insurance to an individual whole life insurance policy, you or your covered dependent must apply to Aetna within 31 days after the date your county coverage ends. If you die during that 31-day period, your beneficiaries or estate will receive the full amount of your life insurance coverage in force before coverage ended. This payment is made whether or not you actually applied to continue coverage. If you already had applied, any fees or premiums you paid are refunded.

For information about converting your life insurance coverage, contact Aetna.

AD&D Insurance

Your AD&D insurance isn't portable. However, you may be eligible to purchase AD&D conversion insurance with CIGNA if your coverage ends because you:

- leave county employment for any reason;
- are no longer eligible (except for age); or
- lose coverage because the CIGNA group policy terminates.

Benefits will differ from the county plan's benefits.

No medical certification is needed, but you and your dependents must be under age 70.

You must apply in writing within 31 days after the date your county coverage ends.

For information about continuing your AD&D insurance, contact CIGNA.

Life Insurance Plan

Life insurance offers you and your family financial protection if you or a covered dependent dies. You may also purchase supplemental life insurance for you and your eligible dependents to increase your coverage.

The benefits offered by the life insurance plan are insured by Aetna. This means that Aetna is financially responsible for claim payments and other costs.

How the Life Insurance Plan Works

The life insurance plan includes:

- basic life insurance, which the county provides to benefit-eligible employees at no cost; and
- supplemental life insurance, which you may purchase as additional coverage for you and your eligible dependents.

If you elect supplemental life insurance for yourself and you die, your beneficiaries receive a benefit equal to the supplemental amount you've purchased **plus** your county-paid basic life insurance. If you elect supplemental life insurance for your eligible dependents, you're the beneficiary of supplemental life insurance if one of your covered dependents dies.

Calculating Life Insurance Benefits

The amount of life insurance benefit you or your beneficiaries receive is calculated from your basic insurance and, if you elected it, your supplemental insurance.

Basic Life Insurance

Your basic life insurance is based on your base annual salary, which is your base pay excluding overtime, bonuses, premium pay or any other special pay. The maximum basic life insurance you may have is $200,000. If you die, your beneficiaries receive a benefit equal to your base annual salary, rounded up to the next $1,000.

Your coverage will increase over time because your basic life benefit automatically increases (up to $200,000) as your salary increases. Adjustments to the basic life insurance benefit due to a salary change automatically occur the month of the salary change, unless you're on an approved unpaid leave. In that case, the adjustment occurs the month you return to active work. If you happen to be ill or injured and away from work on the date your coverage increases, the increase will take effect when you return to work for one full day.

Imputed Income

Under IRS regulations, $50,000 is the maximum **tax-free** life insurance coverage an employer may provide. When your basic life insurance exceeds $50,000, you pay the income tax on the value of county-paid premiums applicable to your coverage above $50,000. The value is added to your paycheck and reflected in your W-2 earnings as "imputed income."

Supplemental Life Insurance

The supplemental life insurance benefit you or your beneficiaries receive depends on the level of coverage you purchase.

Supplemental Life Insurance for You

If you purchase supplemental life insurance and you die, your beneficiaries receive the supplemental life insurance amount you purchased—1, 2, 3 or 4 times your base annual salary—in addition to your basic life insurance.

As with basic life insurance, your supplemental life insurance increases automatically (up to $400,000) as your salary increases. Adjustments to the supplemental life insurance benefit due to a salary change automatically occur the month of the salary change, unless you're on an approved unpaid leave. In that case, the adjustment occurs the month you return to active work. If you happen to be ill or injured and away from work on the date your coverage increases, the increase will take effect when you return to work for one full day.

Supplemental Life Insurance for Your Dependents

If you purchase supplemental life insurance for your spouse/domestic partner and he/she dies, you receive 50% of the supplemental life insurance amount you purchased—that is, 50% of 1, 2, 3 or 4 times your base annual salary. If your spouse/domestic partner's insurance was capped at $100,000, you receive $100,000 or 50% of the amount of supplemental insurance you elected, whichever is less.

If you purchase supplemental life insurance for any of your children and he/she dies, you receive:

- $500 if the child was 14 days up to six months old; or
- $10,000 if the child was age six months up to 25 years old.

Understanding Evidence of Insurability (EOI)

Evidence of insurability (EOI) is any statement of a person's physical condition, occupation or other factor that provides proof that he/she is insurable. Benefits, Payroll and Retirement Operations provides an EOI application when EOI is required under the policy. The application should be completed and returned directly to Aetna within 30 days of receipt.

EOI is required for a spouse/domestic partner when coverage is requested in an amount greater than $100,000 (EOI isn't required if coverage subsequently exceeds $100,000 as the result of your salary increase). The coverage amount above $100,000 doesn't take effect until EOI is approved by Aetna. If EOI isn't received or approved, coverage is capped at $100,000.

If you experience a qualifying life event, no EOI is required for supplemental life insurance up to four times your salary. No EOI is required for eligible children.

Receiving Benefit Payments

It's important for you to know how claims are filed and how benefits are paid.

How to File a Claim

For a death or accelerated claim, you or your beneficiary should contact Aetna to file a claim. When you submit a claim, you'll need to provide your group number: 723832. Benefits, Payroll and Retirement Operations staff will help file the claim with Aetna and provide referrals to counseling and other resources as requested.

Aetna processes the claim within 10 business days following receipt of a complete claim. If Aetna needs more time, you or your beneficiary is notified in writing, within the initial 10 days of receipt of the claim, of the need for an extension of up to 90 days.

Aetna may, at its own expense and unless prohibited by law, have an autopsy performed to determine a death benefit.

If the claim is denied, you or your beneficiary is notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that the plan reviewed in making the determination.

How Benefits Are Paid

Life insurance benefits can be paid at your death or the death of a covered dependent, or in the case of a terminal illness.

In Case of Death

Life insurance benefits are payable if you or a dependent dies while covered under the county plan. If you leave the county and die within 31 days after the date your county coverage ends, your beneficiaries or estate will receive the full amount of your life insurance coverage in force before coverage ended, even if you did not apply to continue your coverage through Aetna.

Insurance is paid in a lump sum and is not subject to federal income tax. Be sure to consult your tax advisor for more information on taxes and death benefits.

How a Lump Sum Is Paid

When a death benefit of $5,000 or more is payable to you or a beneficiary, it is deposited into an Aetna Benefits Checkbook Account in the person's name. This account will earn competitive money market interest rates. You or the beneficiary receives personalized checks for immediate access to all or part of the funds deposited in the account and may write a check for no less than $250.

In Case of Terminal Illness

If you or your covered spouse/domestic partner has a terminal illness, certain benefits may be paid before death. This is called the "accelerated benefit option." You may elect to receive up to 75% of the life insurance benefit (up to $450,000 for you and up to $100,000 for your spouse/domestic partner) while you or your spouse/domestic partner is living if the following requirements are met:

- life expectancy must be 24 months or less; and
- certification of the terminal illness must be provided by a physician legally licensed to practice medicine, and accepted by Aetna before accelerated benefits are paid.

For the following conditions, you may elect to receive up to 75% of the life insurance benefit (up to $450,000 for you and up to $100,000 for your spouse/domestic partner):

- amyotrophic lateral sclerosis (Lou Gehrig's disease);
- end-stage heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate;
- a medical condition requiring artificial life support, without which you would die.
- a permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury, both of which are expected to result in life-long confinement in a hospital or skilled nursing facility.

While an accelerated benefit claim is pending, Aetna has the right, as often as reasonably necessary, to have a covered person examined by a health or vocational professional of Aetna's choice and at Aetna's expense.

Accelerated benefits are based on the amount of life insurance in effect according to county payroll records on the date Aetna accepts the physician's certification of terminal illness. Accelerated benefits are payable in a lump sum. The life insurance benefit is reduced by the amount of the accelerated benefit payment, and the remaining benefit is paid to you or your beneficiary after death.

If you have supplemental life insurance and elect the accelerated benefit option, you must continue paying for supplemental life insurance until coverage ends. However, because the accelerated benefit reduces the amount of your supplemental life insurance, the premium you continue to pay is reduced accordingly, based on the remaining amount of insurance.

For more details about the accelerated benefit option, contact Benefits, Payroll and Retirement Operations.

IMPORTANT THINGS TO KEEP IN MIND

Here are a few important things to know about the accelerated benefit option:

- accelerated benefits can be used to pay for special nursing requirements or hospice arrangements, needed medical equipment, or custodial care and other expenses;
- accelerated benefits are payable only once for you and once for your spouse/domestic partner;
- your accelerated benefit payment reduces the amount of the life insurance benefit that may be converted to an individual policy;
- you're responsible for any taxes due to an accelerated benefit payment; and
- your spouse/domestic partner must agree with your accelerated benefit option election.

Accidental Death and Dismemberment Insurance Plan

Accidental death and dismemberment (AD&D) insurance offers you and your family financial protection if you or a covered dependent dies or suffers a loss as the result of a covered accident. You may also purchase supplemental AD&D insurance for you and your eligible dependents to increase your coverage.

How the AD&D Insurance Plan Works

EOI ISN'T REQUIRED

You're not required to provide evidence of insurability (EOI) to enroll in AD&D insurance.

The accidental death and dismemberment (AD&D) insurance plan pays benefits if you or a covered dependent dies or suffers a specified dismemberment, paralysis or other loss that occurs within 365 days of a covered accident.)

The plan includes:

- basic AD&D insurance, which the county provides to benefit-eligible employees at no cost; and
- supplemental AD&D insurance, which you may purchase as additional coverage for you and your eligible dependents.

If you elect supplemental AD&D insurance for yourself and you die as the result of a covered accident, your beneficiaries receive a benefit equal to the supplemental amount you've purchased **plus** your county-paid basic AD&D insurance benefit. If you elect supplemental AD&D insurance for your eligible dependents, you're the beneficiary of supplemental AD&D insurance if one of your covered dependents dies as the result of a covered accident.

Calculating AD&D Insurance Benefits

The amount of AD&D insurance benefit you or your beneficiaries receive is based on the amount of your basic AD&D insurance and, if you elected it, the amount of your supplemental AD&D insurance.

Basic AD&D Insurance

Your basic AD&D insurance is based on your base annual salary, which is your base pay excluding overtime, bonuses, premium pay or any other special pay. The maximum basic AD&D insurance you may have is $200,000. If you die, your beneficiaries receive a benefit equal to your base annual salary, rounded up to the next $1,000 (up to the $200,000 maximum).

Your coverage will increase over time because your basic AD&D benefit automatically increases (up to $200,000) as your salary increases. Adjustments to the AD&D insurance benefit due to a salary change automatically occur on the first day of the month following the salary change, unless you're on an approved unpaid leave. In that case, the adjustment occurs on the first day of the month following the date you return to active work. If you happen to be ill or injured and away from work on the date your coverage increases, the increase will take effect when you return to work for one full day.

Supplemental AD&D Insurance

The supplemental AD&D insurance benefit you or your beneficiaries receive depends on the level of coverage you purchase.

Supplemental AD&D Insurance for You

If you purchased supplemental AD&D insurance and you die as the result of a covered accident, your beneficiaries receive the supplemental AD&D insurance amount you purchased—from $50,000 to $500,000—in addition to your basic AD&D insurance.

After supplemental AD&D insurance has been in effect for 12 consecutive months, supplemental coverage for you increases 1% every January 1 until it's been increased by a maximum of 10%. Each year's increase is calculated on the previous year's coverage amount. There is no additional cost for this "escalated" coverage.

Supplemental AD&D Insurance for Your Dependents

If you purchase supplemental AD&D insurance for your spouse/domestic partner and he/she dies as the result of a covered accident, you receive 100% of the supplemental AD&D insurance you purchased for yourself.

If you purchase supplemental AD&D insurance for any of your children and he/she dies as the result of a covered accident, you receive 10% of the supplemental AD&D insurance you purchased for yourself.

After supplemental AD&D insurance has been in effect for 12 consecutive months, supplemental coverage for your covered dependents increases 1% every January 1 until it's been increased by a maximum of 10%. Each year's increase is calculated on the previous year's coverage amount. There is no additional cost for this "escalated" coverage.

Schedule of Benefits

IMPORTANT!

To receive benefits, you or your covered dependent must be covered under the plan on the date of the accident.

AD&D insurance protects you against losses due to accidents. Depending on the type of loss or injury, the plan pays up to 100% of the full AD&D benefit amount for you or your spouse/domestic partner, subject to reductions for age, and up to 200% of the full AD&D benefit amount for your covered children.

To help survivors of severe accidents adjust to new living circumstances, certain benefits are payable for paralysis, dismemberment, and loss of eyesight, speech or hearing according to the following table. Benefits are payable for death, specified dismemberment, paralysis and other losses that occur within 365 days of the covered accident that caused the covered loss.

If the covered person suffers loss of...	You or your spouse/ domestic partner receives...	Your children receive...
• Life • Both hands or both feet, or sight in both eyes, or any combination • Speech and hearing in both ears • Quadriplegia (total paralysis of both arms and legs)	Full benefit amount	100% of the full benefit amount for loss of life; 200% of the full benefit amount for other losses listed
• Paraplegia (total paralysis of both legs) • 1 arm or 1 leg	75% of the full benefit amount	150% of the full benefit amount
• 1 hand or 1 foot or sight in 1 eye • Speech • Hearing in both ears • Paralysis of 1 arm and 1 leg	50% of the full benefit amount	100% of the full benefit amount
• Thumb and index finger on the same hand • Paralysis of 1 arm or 1 leg	25% of the full benefit amount	50% of the full benefit amount

Only one amount—the largest you're entitled to receive—is paid for all losses resulting from a single accident.

A "loss" is defined as:

- loss of arm or leg—complete severance at or above the elbow or knee joint;
- loss of hearing—irrecoverable loss of hearing that cannot be corrected by any hearing aid or device;
- loss of hand or foot—complete severance of a limb at or above the wrist or ankle joint;
- loss of sight—total and irrecoverable loss of sight;
- loss of speech—complete inability to communicate audibly in any degree;
- loss of thumb and index finger—complete severance of the thumb and index finger through or above the joint closest to the wrist;
- paralysis of a limb—complete and irreversible loss of use without severance of a limb, which is the complete separation and dismemberment of the limb from the body (this loss must be determined by a physician to be complete and irreversible).

Reduction in Benefits

For you and a covered spouse/domestic partner, supplemental AD&D benefit amounts are reduced to:

70% of the benefit amount for ages 70–74; and 45% of the benefit amount for ages 75–79; For you, supplemental AD&D benefit amounts are reduced to:

- 30% of the benefit amount for ages 80–84 (applies to employee only); and
- 15% of the benefit amount for ages 85 and over (applies to employee only).

Additional Benefits

AD&D insurance offers some benefits in addition to AD&D coverage.

Brain Damage Benefit

The plan pays an additional benefit if you or a covered dependent sustains brain damage as the result of a covered accident. This benefit is payable if:

- brain damage occurs within 365 days following the accident;
- the covered person is hospitalized for at least seven days within 365 days following the accident;
- brain damage continues for 12 consecutive months; and
- a physician determines that brain damage is permanent, complete and irreversible at the end of 12 consecutive months.

The plan pays the lesser of $100,000 or 50% of your AD&D benefit in one lump sum during the 13th month following the date of the covered accident. The amount payable by this brain damage benefit and any amount the plan paid or owes under the dismemberment, loss of sight, speech or hearing, and paralysis benefit will not exceed the full benefit amount.

Child Care Benefit

A child care benefit is payable at the time of death or within one year of a covered accident if:

- you elected supplemental AD&D insurance for your child;
- you or your covered spouse/domestic partner dies as the result of a covered accident; and
- you have a surviving child under age 13 in a licensed child care center (or your child is enrolled within 365 continuous days of the covered accident).

The child care benefit pays an annual sum for each covered child of up to 5% of your supplemental AD&D benefit, up to $5,000 a year, until the child enters first grade or for five straight years, whichever occurs first. To qualify for this benefit, your child must continue to be enrolled in a licensed child care center.

If, at the time of the accident, coverage for a dependent child is in force but no dependent child qualifies for a benefit payment, your designated beneficiary receives an additional benefit payment of $1,500.

Payment is made to your surviving spouse, if he/she has custody of the child. If you do not have a surviving spouse, or the child doesn't live with your spouse, then payment is made to the child's legal guardian. Each payment is made at the end of a 12-month period once documented child care center expenses have been provided.

Coma Benefit

The plan pays an additional benefit if you or a covered dependent enters a coma as the result of a covered accident within 31 days of the accident and remains comatose beyond the waiting period. After the covered person has been comatose for 31 days, the plan makes monthly payments of 1% of the full AD&D benefit—up to 11 monthly payments. If the comatose person recovers, payments stop.

If you or your dependent dies as the result of a covered accident while receiving the monthly coma benefit, the plan pays the full benefit amount (the amount already paid isn't subtracted from the death benefit) minus any amount the plan paid or owes under the dismemberment, loss of sight, speech or hearing, and paralysis benefits.

If the coma continues after the 11 monthly payments, the covered dependent is entitled to a lump sum equal to the full benefit amount, minus any amount the plan paid or owes under the benefit for dismemberment, loss of sight, speech or hearing, and paralysis. No further benefit will be paid from this plan, and coverage will end.

No coma benefit will be paid for any loss excluded from the plan. In addition, the coma benefit isn't payable for a loss resulting from sickness, disease, bodily infirmity, medical or surgical treatment, bacterial infection (unless it results from an accidental external injury or food poisoning) or viral infection.

Education Benefit

If you elect supplemental AD&D insurance for your child and you or your covered spouse/domestic partner dies in a covered accident, the plan pays an education benefit for each covered child who, on the date of the accident:

- is enrolled in an accredited school of higher learning; or
- is in the 12th grade and enrolled in an accredited school of higher learning within 365 days of the accident.

To help pay expenses, your benefit amount increases by 5% to up to $5,000 for each qualifying child. This benefit is payable each year for four consecutive years as long as the child continues his/her education.

If you don't have a qualifying child, your beneficiary receives an additional $1,000.

Felonious Assault Benefit

If you're injured or killed as the result of felonious assault while on county property or on county business, the plan pays up to an additional 25% of your basic AD&D benefit, up to $100,000. This felonious assault benefit is available if your injury or death is the result of an actual or attempted robbery or holdup (or kidnapping associated with a holdup). Felonious assaults inflicted by county employees or members of your family or household aren't covered.

Identity Theft Program

If you are enrolled in accident or disability, the CIGNA identity theft program is available with the following services provided:

- a review of credit information to determine if an identity theft has occurred;
- an identity theft resolution kit and an identity theft affidavit for credit bureaus and creditors;
- help with reporting an identity theft to credit reporting agencies;
- assistance with placing a fraud alert on credit reports, and cancellation and replacement of lost or stolen credit cards;
- assistance with replacement of lost or stolen documents;
- access to free credit reports;
- education on how to identify and avoid identity theft;
- $1,000 cash advance to cover financial shortages if needed;
- emergency message relay; and
- help with emergency travel arrangements and translation services.

Increased Benefit for Children

If you elected supplemental AD&D insurance for your child and he/she has a covered accidental injury:

- you receive double the AD&D benefit amount, up to $50,000. If your child has two covered losses, only the larger amount payable will be doubled. If, in addition to a covered loss, your child dies because of the accident, only the death benefit is payable.
- this benefit can help you cope with the ongoing financial obligations for a child who requires ongoing medical attention, rehabilitation services and a specialized education.

Rehabilitation Benefit

If you or a covered dependent experiences a covered loss or injury, the plan pays an additional benefit for covered rehabilitative expenses due to the loss or injury if they're incurred within two years of a covered accident. This benefit maximum is $10,000 in rehabilitative expenses for all losses or injuries caused by the same accident. No rehabilitation benefit will be paid for any loss not covered by the plan. In addition, benefits won't be payable if a covered person is entitled to benefits under any workers' compensation act or similar law.

Seatbelt/Airbag Benefit

The plan pays an additional benefit of 10% of the full AD&D benefit amount, up to $25,000, if a seatbelt fails to protect you or a covered dependent and death results. The accident causing death must occur while the covered person is operating, or riding as a passenger in, an automobile and wearing a properly fastened, original, factory-installed seatbelt. A child restraint—as defined by state law and approved by the National Highway Traffic Safety Administration—properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the accident also qualifies as a seatbelt.

The plan pays an additional 5% of the full AD&D benefit amount, up to $12,500, if a seatbelt benefit is payable and the covered person is positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact (often called an "airbag").

Verification of actual seatbelt use at the time of the accident and airbag inflation at impact must be part of an official accident report or be certified, in writing, by the investigating officer. If that certification isn't available or if it's unclear whether the covered person was wearing a properly fastened seatbelt or positioned in a seat protected by a properly functioning and properly deployed supplemental restraint system, the designated beneficiary receives a fixed benefit of $1,000.

CIGNA Secure Travel®

If you or a covered dependent travels 100 or more miles from home, pre-trip planning and traveling and emergency assistance are available through CIGNA Secure Travel® 24 hours a day, 365 days a year. (See *Contact Information*.)

Pre-trip Planning

Pre-trip planning includes the following information:

- immunization requirements;
- visa and passport regulations;
- embassy/consular referrals;
- foreign exchange rates;
- travel advisors and weather conditions; and
- cultural information.

*Traveling Assistance**

When you're traveling, CIGNA Secure Travel® includes:

- 24-hour multilingual assistance and referral to interpretation and translation services;
- referral to physicians, dentists, medical facilities and legal assistance providers;
- arrangements for payment of medical expenses up to $10,000 if required prior to treatment**;
- assistance with lost or stolen items, including luggage and prescription replacement services;
- emergency cash—advance up to $1,500**; and
- advancement of bail**.

Emergency Assistance

If an unforeseen emergency arises while you're traveling, CIGNA Secure Travel® provides the following:

- emergency evacuation and repatriation, when medically necessary; arrange and cover the cost of transportation to the nearest adequate medical facility***;
- travel arrangements for the return of dependent children under the age of 18 and/or the employee's traveling companion, who are left unattended due to the covered employee's medical emergency;
- round-trip transportation as well as accommodation up to $150 per day for up to seven days for a family member or friend to visit a covered employee who is hospitalized more than 100 miles away from home for more than seven days;
- arrange and cover the costs associated with returning a deceased covered employee's remains to his/her place of residence for burial;
- emergency message relay toll-free; and
- assistance with making emergency travel arrangements**.

* Services for medically necessary transport, return of dependent children, return of travel companion, visit of a family member/friend and repatriation of remains are covered by the CIGNA Secure Travel program. Expenses for medical care are not covered.

** Covered employee is responsible for any advances, payments, travel-related or replacement costs and must provide confirmation of reimbursement. Credit card(s) used to guarantee reimbursement must have sufficient available limit to cover the amount of the advance.

*** Initial transport by ambulance following a covered medical emergency occurring in the United States is excluded.

Violent Crime Benefit

This benefit pays up to an additional 25% of your supplemental AD&D benefit amount, up to $100,000, if you or a covered dependent suffers a covered loss due to a violent crime. The plan also pays an additional benefit for hospital confinement as the result of a violent crime—$100 a day up to 10 days (hospital confinement must begin within one year of the crime).

This violent crime benefit applies to:

- actual or attempted robbery or holdup;
- actual or attempted kidnapping; and
- any other type of assault classified as a felony based on governing statute or common law in the state where it occurred.

A copy of a police report containing proof that the loss was a direct result of a covered crime must be provided before any AD&D benefit is paid.

Receiving Benefit Payments

It's important that you know how claims are filed and how benefits are paid.

How to File a Claim

For a death, specified dismemberment or paralysis claim, you or your beneficiary should contact Benefits, Payroll and Retirement Operations. Benefits, Payroll and Retirement Operations staff will help file the claim with CIGNA and provide referrals to counseling and other resources as requested. The claim should be filed within 90 days of the loss or death. The group number for AD&D insurance is OK821586.

CIGNA requires proof of loss—for example, a certified copy of the death certificate or accident report—within 90 days of the loss, or as soon as reasonably possible, before benefits are payable. For a death claim, CIGNA may, at its own expense and unless prohibited by law, have an autopsy performed to determine a death benefit. While a dismemberment or paralysis claim is pending, CIGNA may have the covered person examined by a health or vocational professional of his/her own choice at his/her expense, as often as reasonably necessary.

CIGNA processes the claim within 90 days of receipt. If CIGNA needs more time, you or your beneficiary is notified in writing, before the initial 90 days end, of the need for an extension of up to 90 days.

If the claim is denied, you or your beneficiary is notified in writing of reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim which the plan reviewed in making the determination.

How Benefits Are Paid

AD&D insurance benefits are payable if you or a covered dependent dies or suffers a covered loss as the result of a covered accident.

Benefits are paid in a lump sum and aren't subject to federal income tax. Be sure to consult your tax advisor for more information on taxes and death benefits.

Understanding Exclusions and Limitations

No AD&D benefits are paid for loss resulting from:

- an accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Accidents that occur while the covered person is engaged in Reserve or National Guard training aren't excluded;
- commission of a felony;
- declared or undeclared war or act of war;
- the covered person performing any of the following:
  - piloting, serving as a crew member or taking flying lessons (exclusion doesn't apply if riding as a passenger);
  - hang gliding; and
  - parachuting, except a parachute jump for self-preservation;
- sickness, disease, bodily or mental infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how contracted (except bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning); or
- travel or flight in (including getting in or out, on or off) any aircraft or device that can fly above the earth's surface, if the aircraft or device is being used for any of these purposes:
  - for test or experiment;
  - by or for any military authority (aircraft flown by the U.S. Military Airlift Command or similar service of another country aren't excluded);
  - for travel beyond the earth's atmosphere; and
  - by or for King County or any of its subsidiaries or affiliates, regardless of whether the aircraft is owned, leased, operated or controlled. Chartered aircraft are not excluded.

GLOSSARY

Base annual salary

"Base annual salary" is your base pay excluding overtime, bonuses, premium pay or any other special pay.

Beneficiary

A "beneficiary" is the person or organization you designate to receive any life or AD&D insurance benefits payable at the time of your death.

Covered rehabilitative expense

A "covered rehabilitative expense" is an expense that:

- is charged for medically necessary rehabilitative training service of the covered person performed under the care, supervision or order of a physician;
- doesn't exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a hospital room and board charge, doesn't exceed the most common charge for semiprivate room and board in the hospital where the expense is incurred); and
- doesn't include charges that wouldn't have been made if there were no insurance.

Disabled—Life insurance

You're considered permanently and totally "disabled" only if disease or injury prevents you from working at your own job or any other job for pay or profit, and continues to prevent you from working at any reasonable job. A "reasonable job" is any job for pay or profit that you are (or may reasonably become) fitted for by education, training or experience.

Evidence of insurability (EOI)

"Evidence of insurability (EOI)" is any statement of a person's physical condition, occupation or other factor that provides proof that he/she is insurable.

Limitation

A "limitation" is any restricting condition, such as age, time covered and waiting periods.

Medically necessary rehabilitative training service

A "medically necessary rehabilitative training service" is any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that is essential for physical rehabilitative training due to the injury for which it is prescribed or performed and that meets generally accepted standards of medical practice and is ordered by a doctor.

Rules, Regulations and Administrative Information

This section of *Your King County Benefits* discusses your legal rights and presents some important administrative information.

Insurance and Administrative Contracts

The benefit descriptions in this guide provide you with most of the information you'll need to know about your King County benefit package. However, they're not detailed descriptions. If you have questions about specific plan details or would like to review any of the insurance and administrative contracts, you may contact the plan's third-party administrator or Benefits, Payroll and Retirement Operations.

The county has made every attempt to ensure the accuracy of the information in this guide. However, if there is any discrepancy between the benefit descriptions in this guide and the insurance and administrative contracts, the contracts will always govern. In addition, no person has the authority to make any oral or written statements of any kind that would conflict with the contracts or would alter the contracts maintained in conjunction with the plans.

Your Patient Rights

When you're covered under the county health plans, you have certain rights and responsibilities the county wants you to know about.

Dignity and Respect Under Your Health Plans

You have the right to:

- be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients; and
- see your own health records and have those records kept private and confidential unless required to settle a claim, for plan operations, for payment of claims, and as required by law.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

Knowledge and Information Concerning Your Health Plans

You have the right and the responsibility to know about and understand your health care and your coverage, including:

- names and titles of all providers involved in your care;

- your health condition and status;
- services and procedures involved in your treatment;
- ongoing health care you need once you're discharged or leave the provider's office;
- how the plans work (see the appropriate plan sections of this guide); and
- any medication prescribed for you—what it is, what it's for, how to take it properly and possible side effects.

You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you're responsible for following that plan or telling your provider otherwise.

Medical Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

- refuse treatment as long as you accept the responsibility and consequences of that decision;
- complete an advance directive, such as a living will or durable power of attorney, for care;
- refuse to take part in any health care research projects;
- be advised on the full range of treatment options (whether or not covered under the plans) and their potential risks, benefits and costs; and
- make the final choice among treatment alternatives.

You're also responsible for:

- identifying yourself and covered dependents to providers when you receive services by showing your plan ID card (if provided by your plan) or providing your complete Social Security number (or unique identifier number if issued by the plan);
- giving your current provider all previous and relevant health care records and submitting accurate, complete health information to all physicians or other providers involved in your care;
- being on time for appointments and letting your provider's office know as far in advance as you can if you need to cancel or reschedule;
- following instructions given by those providing your care;
- sending copies of claim statements or other documents if requested;
- letting your medical plan and primary care provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care;
- telling the plan and your primary care provider (if applicable) about planned health care treatment, such as a surgery or an inpatient stay; and
- paying all required expenses not covered by the plan.

If you decide to give someone else the legal power to make decisions about your health care, that person also will have all of these rights and responsibilities.

Privacy Protection

To protect your privacy, the county and your plans limit the use of Social Security numbers unless otherwise legally required. Instead, the county and the plans use your PeopleSoft employee ID or a unique identifier number on ID cards, explanations of benefits or any other correspondence sent to you.

Continuous Improvement of Your Health Plans

You have the right to:

- contact Benefits, Payroll and Retirement Operations with any questions or concerns and make suggestions for improving the plans;
- ask your providers to explain or give you more information about any health advice or prescribed treatment; and
- appeal any health care or administrative decisions.

Your HIPAA Privacy Rights

This section of your guide describes how medical information about you may be used and disclosed by King County and how you can get access to this information. Please review all information carefully and, if you have any questions, contact Benefits, Payroll and Retirement Operations.

Our Obligations

We treat all protected health information (personally identifiable medical information) that you provide us to administer your health benefits as confidential. In addition, under the Health Insurance Portability and Accountability Act (HIPAA), we must:

- maintain the privacy of any protected health information you provide us when you enroll in benefit coverage, change coverage or ask for our assistance with a health benefit claim;
- inform you if there has been an inadvertent disclosure of your protected health information;
- obtain agreements with all vendors involved with the county's benefit plans to comply with HIPAA rules and regulations; and
- provide you with this information, which advises you of how we handle your protected health information and informs you of our legal obligations and your rights regarding the information.

For a complete summary of King County's obligations, refer to the "HIPAA Notice of Privacy Practices" on the Benefits, Payroll and Retirement Web site under Your King County Benefits.

How We May Use and Disclose Protected Health Information

When you enroll in benefit coverage, change coverage or ask for our assistance with a health benefit claim, you provide us with information such as your name and possibly your Social Security number. Sometimes, when you ask for our assistance with a claim, you may also provide us with details about the health treatments you've received and payments for services you've made. This information becomes "protected health information" when used and disclosed in the course of managing our health care operations (administering your health benefits) and facilitating payment of health claims.

We may use and disclose this protected health information to:

- our employees authorized to assist in the administration of county benefit plans; and
- representatives of the plans or any third-party administrators with whom we have agreements to provide your benefit services.

In addition, we may use or disclose protected health information:

- when required by law—for example, in response to a court or administrative order, subpoena or discovery request; and
- when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

For all the reasons explained above, we may use and disclose your personal health information without your written authorization. In all other cases, your written authorization is required.

Your Rights

For any protected health information provided to and maintained by us, you have the right to:

- inspect and copy it;
- request amendments to it if it's incorrect or incomplete (we may deny amendment requests for specific reasons—for example, we deny requests to amend information we didn't create);
- request to know to whom it's been disclosed for non-routine purposes (for disclosures made after April 14, 2003, when these HIPAA privacy practices became effective);
- request restrictions on what is disclosed and to whom (we try to honor restriction requests but are not required to do so); and
- request it be communicated to you in a certain way—for example, that we contact you only by mail or at work (we try to honor these requests but are not required to do so).

Changes to Our Privacy Practices

We reserve the right to change our privacy practices and to apply the new practices to protected health information we already have, as well as to any information we receive in the future. We'll announce or notify you of any changes in our privacy practices and when the changes become effective.

Complaints

If you believe your privacy rights have been violated, you may file a complaint in writing with Benefits, Payroll and Retirement Operations or the Office of Civil Rights within the U.S. Department of Health and Human Services. You won't be penalized for filing a complaint.

Claims Review and Appeals Procedures

The procedures for filing claims for benefits are summarized in the respective plan overviews. If you're not satisfied with the outcome of your claim, you can ask to have the claim reviewed.

Almost all of the benefit plans described in this guide have a specific amount of time during which benefit claims can be evaluated and responded to. The period of time the plans have to evaluate and respond to a claim begins on the date the claim is first filed. In addition, there are specific timelines and information requirements that you must comply with when filing a claim, or the claim may be denied and the rights you might otherwise have may be forfeited.

As the plan administrator, King County has the authority to control and manage the operation and administration of the plans described in this guide. However, the county can assign specific operational or administrative responsibilities, such as processing claims, to a third-party administrator, which has final responsibility and authority for responding to claims appeals.

Regence, for example, has the responsibility for processing claims and handling claims appeals for the county's KingCare℠ plan. Group Health Cooperative, on the other hand, makes final decisions for benefit appeals for the county's Group Health plan.

Health Care Plans

In most cases, your health care provider will submit claims for health care services on your behalf. However, either you or your authorized representative may file claims for benefits under the county's health care plans (that is, medical, prescription drug, dental and vision). An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plans also will recognize a court order giving a person the authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the plans will be directed to your authorized representative unless your written designation provides otherwise.

KingCare℠

If a properly filed medical claim is denied in whole or in part, a KingCare℠ service representative will notify you and your provider with an explanation in writing. KingCare℠ may deny a claim on the basis of eligibility or for other reasons.

Claims Denied for Reasons Other Than Eligibility

Appeal Process

If you or your representative (any representative authorized by you) has a concern regarding a claim denial or other action under the plan and wishes to have it reviewed, you may appeal. There are two levels of appeal, as well as additional voluntary appeal levels you may pursue. Certain matters requiring quicker consideration qualify for a level of expedited appeal and are described later in this section.

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the claims administrator at:

Regence BlueShield
Attn: Appeals
P.O. Box 2998
Tacoma, WA 98401-2998
Fax 1-877-663-7526

Verbal requests can be made by calling the claims administrator at 1-866-240-9580.

Each level of appeal, except voluntary external review, must be pursued within 180 days of your receipt of the claims administrator's determination (or, in the case of the first level, within 180 days of your receipt of the claims administrator's original adverse decision that you are appealing). If you don't appeal within this time period, you will not be able to continue to pursue the appeal process and may jeopardize your ability to pursue the matter in any forum. If your health could be jeopardized by waiting for a decision under the regular appeal process, an expedited appeal may be requested. Please see "Expedited Appeals" later in this section for more information.

First-Level Appeals

First-level appeals are reviewed by a claims administrator employee or employees who were not involved in the initial decision that you are appealing. In appeals that involve issues requiring medical judgment, the decision is made by the claims administrator's staff of health care professionals. For post-service appeals, a written notice of the decision will be sent within 30 days of receipt of the appeal. For appeals involving a pre-service preauthorization of a procedure, the claims administrator will send a written notice of the decision within 14 days of receipt of the appeal.

Panel-Level (Second-Level) Appeals

Second-level appeals are reviewed by a panel of claims administrator employees who were not involved in, or subordinate to anyone involved in, the first-level decision. You or your representative on your behalf, will be given a reasonable opportunity to provide written materials. For post-service appeals, a written notice of the decision will be sent within 30 days of receipt of the appeal. For appeals involving a pre-service preauthorization of a procedure, the claims administrator will send a written notice of the decision within 14 days of receipt of the appeal.

Voluntary External Appeals – IRO

A voluntary appeal to an Independent Review Organization (IRO) is available for issues involving medical judgment (including, but not limited to, those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered service; or the determination that a treatment is investigational), but only after you have exhausted all of the applicable non-voluntary levels of appeal, or if the claims administrator has failed to adhere to all claims and internal appeal requirements. Voluntary external appeals must be requested within four months of your receipt of the notice of the prior adverse decision.

The claims administrator coordinates voluntary external appeals, but the decision is made by an IRO at no cost to you. The claims administrator will provide the IRO with the appeal documentation. The IRO will make its decision and provide you with its written determination within 45 days after their receipt of the request. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under state or federal law.

The voluntary external appeal by an IRO is optional and you should know that other forums may be utilized as the final level of appeal to resolve a dispute you have under the plan. This includes but is not limited to civil action under section 502(a) of ERISA, where applicable.

Expedited Appeals

An expedited appeal is available if one of the following applies:

- the application of regular appeal timeframes on a pre-service or concurrent care claim could jeopardize your life, health or ability to regain maximum function; or
- according to a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the disputed care or treatment.

Panel-Level (First-Level) Expedited Appeals

The first-level expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. First-level expedited appeals are reviewed by a panel of claims administrator's employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. You, or your representative on your behalf, will be given the opportunity (within the constraints of the expedited appeals timeframe) to participate via telephone and/or provide written materials. A verbal notice of the decision will be provided to you and your representative as soon as possible after the decision, but no later than 72 hours of receipt of the appeal. A written notification of the decision will be mailed to you within three calendar days of the verbal notification.

Voluntary Expedited Appeal – IRO

If you disagree with the decision made in the panel-level appeal and you or your representative reasonably believes that preauthorization remains clinically urgent (pre-service or concurrent), you may request a voluntary expedited appeal to an IRO. The criteria for a voluntary expedited appeal to an IRO are the same as described above for non-urgent expedited appeal.

The claims administrator coordinates voluntary expedited appeals, but the decision is made by an IRO at no cost to you. The claims administrator will provide the IRO with the appeal documentation. Verbal notice of the IRO's decision will be provided to you and your representative by the IRO as soon as possible after the decision, but no later than within 72 hours of its receipt of your request, followed by written notification within 48 hours of the verbal notification. Choosing the voluntary expedited appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary expedited appeal by an IRO is optional and you should know that other forums may be used as the final level of expedited appeal to resolve a dispute you have under the plan, including, but not limited to, civil action under section 502(a) of ERISA, where applicable.

If you have any questions about the appeal process outlined here, you may contact the claims administrator's customer service department at 1-866-240-9580 or you can write to the claims administrator's customer service department at:

Regence BlueShield
P.O. Box 2998
Tacoma, WA 98401-2998
Fax 1-877-663-7526

Definitions Specific to the Appeals Process

Appeal means a written or verbal request from a claimant or, if authorized by the claimant, the claimant's representative, to change a previous decision made under the plan concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a claimant and the plan; and
- other matters as specifically required by state law or regulation.

Independent Review Organization (IRO) is an independent physician review organization which acts as the decision-maker for voluntary external appeals and voluntary expedited appeals, through an independent contractor relationship with the claims administrator and/or through assignment to the claims administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the claims administrator.

Post-service means any claim for benefits under the plan that is not considered pre-service.

Pre-service means any claim for benefits under the plan which must be approved in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents you for the purpose of the appeal. The representative may be your personal representative or a treating provider. It may also be another party, such as a family member, as long as you or your legal guardian authorize in writing, disclosure of personal information for the purposes of the appeal. No authorization is required from the parent(s) or legal guardian of a claimant who is an unmarried and dependent child and is less than 13 years old. For expedited appeals only, a health care professional with knowledge of your medical condition is recognized as your representative. Even if you have previously designated a person as your representative for a previous matter, an authorization designating that person as your representative in a new matter will be required (but redesignation is not required for each appeal level). If no authorization exists and is not received in the course of the appeal, the determination and any personal information will be disclosed to you or your treating provider only.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because KingCare℠ indicates you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving a notice of your eligibility determination from the county or KingCare℠ to submit a written appeal. It must include:

- your name and address, as well as each covered dependent's name and address, if applicable;
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a covered dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

A Benefits, Payroll and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 1-206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);

- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits, Payroll and Retirement Operations has sole discretionary authority to determine benefit eligibility under KingCare℠, and its decision is final and binding. In reviewing your claim, Benefits, Payroll and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits, Payroll and Retirement Operations determines that you're entitled to benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits, Payroll and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits, Payroll and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your dependent is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under KingCare℠, you and your family members authorize:

- any provider to disclose to Regence any requested medical information;
- Regence to examine your medical records at the offices of any provider;
- Regence to release to or obtain from any person or organization any information necessary to administer your benefits; and
- Regence to examine records that would verify eligibility.

Regence will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Prescription Coverage

Claims Denied for Reasons Other Than Eligibility

If you disagree with the decision on your claim for prescription drug coverage, you (or your authorized representative) will have 180 days to file a written appeal after your receipt of the notice of adverse decision. The decision on your appeal will be based on all comments, documents, records and other information you submit, even if they weren't submitted or considered during the initial claim decision.

APPEALS OF AN ADVERSE DECISION

Mail appeals of an adverse decision to:

Express Scripts, Inc.
Attn: Pharmacy Appeals (KCW)
6625 West 78th Street
Mail Route: BL0390
Bloomington, MN 55439

You should include the reasons you believe the claim was improperly denied, and all additional facts and documents you consider relevant in support of your appeal. The following type of information is helpful when submitting your appeal so that it may be handled in a timely manner:

- employee's full name;
- patient's full name;
- your Express Scripts ID Number (located on the front of your prescription card);
- the date(s) services were provided;
- your mailing address;
- your daytime phone number(s);
- your e-mail address (if you would like to provide it);
- relevant information regarding the nature of your appeal; and
- a copy of your Explanation of Benefits, if applicable.

A new decision-maker will review your denied claim—the appeal will not be conducted by the individual who denied the initial claim. The new decision-maker will not give deference to the original decision on your claim. The reviewer will make an independent decision about the claim. If your claim was denied on the basis of medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim.

For appeals of adverse decisions involving urgent care claims, the plan will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between Express Scripts and you or health plan providers by telephone, fax or other available expeditious methods.

Notice of Decision on Appeal

After your appeal is reviewed by Express Scripts, you'll receive a notice of decision on appeal within the time frames specified below. The time frames for providing a notice of decision on appeal generally begin when all necessary information has been received to perform the review. Notice of decision on appeal will be provided in writing. Urgent care decisions may be delivered by telephone, fax or other expeditious methods. The time frames for providing a notice of decision on appeal are as follows:

- urgent care appeals. As soon as possible considering the medical urgency, but no later than 72 hours after Express Scripts receives your appeal and all information necessary to perform review; and
- claim denial appeals. Within a reasonable period of time appropriate to the medical circumstances, but no later than 10 business days after Express Scripts receives your appeal and all information necessary to perform review.

If the appeal is denied, legal remedies may be pursued, but you or your representative must first exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years of the date of service on which the claim is based, or you forfeit your right to legal action.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because Express Scripts indicates that you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative may file a written appeal with Benefits, Payroll and Retirement Operations. You have 180 days after receiving a notice of your eligibility determination from the county or Express Scripts to submit a written appeal. It must include:

- your name and address, as well as each dependent's name and address, if applicable;
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

A Benefits, Payroll and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 1-206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);
- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits, Payroll and Retirement Operations has sole discretionary authority to determine benefit eligibility under the prescription drug plan, and its decision is final and binding. In reviewing your claim, Benefits, Payroll and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits, Payroll and Retirement Operations determines that you're entitled to benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits, Payroll and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits, Payroll and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your dependent is denied plan participation, or you forfeit your right to legal action.

Group Health

If a properly filed claim is denied in whole or in part, a Group Health Cooperative service representative will notify you and your provider with an explanation in writing. Group Health may deny a claim on the basis of eligibility or medical necessity, or for other reasons.

Group Health has in place certain grievance processes that enable plan members to file a complaint and appeal a denial of benefits:

- the complaint process enables plan members to express dissatisfaction with customer service or the quality or availability of a health service; and
- the appeals process enables plan members to seek reconsideration of a denial of benefits.

Complaint Process

If you wish to file a complaint, you must follow these steps:

Step 1: Contact the provider, and explain your concerns and what you would like done to resolve the problem. Be specific and make your position clear.

Step 2: If you prefer not to talk with the provider or if you're not satisfied with the response, call the department head or the manager of the medical center or department where you're having a problem. That person will investigate your concerns. Most concerns can be resolved in this way.

Step 3: If you're not satisfied with the response, call the Group Health Customer Service Center at 1-888-901-4636 toll-free. Most concerns are handled by phone within a few days. In some cases, you'll be asked to write down your concerns and state what you think would be a fair resolution to the problem. A customer service representative or Member Quality of Care coordinator will investigate your concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of your written statement.

Claims Denied for Reasons Other Than Eligibility

If you wish to appeal a decision denying benefits, you must follow these steps:

Step 1: Submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why you disagree with the decision. The appeal must be submitted within 180 days of the denial notice you received. Send your appeal to:

Group Health's Member Appeals Department
P.O. Box 34593
Seattle, WA 98124-1593

Or, you may call 1-866-458-5479 toll-free.

An Appeals Coordinator will review initial appeal requests. Group Health will then notify you of its determination or need for an extension of time within 30 days of receiving your request for appeal. **Under no circumstances will the review time frame exceed 30 days without your written permission.**

If the appeal request is for an experimental or investigational exclusion or limitation, Group Health will make a determination and notify you in writing within 30 working days of receipt of a fully documented request. If additional time is required to make a determination, Group Health will notify you in writing that an extension in the review time frame is necessary. **Under no circumstances will the review time frame exceed 30 days without your written permission.**

An expedited appeals process is in place for cases that meet criteria or where your provider believes that the standard 30-day appeal review process will seriously jeopardize your life, health or ability to regain maximum function or subject you to severe pain that cannot be managed adequately without the requested care or treatment. You can request an expedited appeal in writing to one of the addresses listed previously. Or, you may call Group Health's Member Appeals Department at 1-866-458-5479 toll-free.

Your request for an expedited appeal will be processed and a decision issued no later than 72 hours after receipt.

Step 2: If you're not satisfied with the decision in Step 1 regarding a denial of benefits, or if Group Health fails to grant or reject your request within the applicable required time frame, you may request a second-level review by an external independent review organization as long as the appeal meets the following requirements:

- in Group Health's judgment, the requested service or supply is not medically necessary or is experimental or investigational, and
- you would be financially responsible for $500 or more of the cost of the service or supply.

An independent review organization isn't legally affiliated with or controlled by Group Health. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through Group Health. You must request a review by an independent review organization within 180 days after the date of the Step 1 decision notice or within 180 days after the date of a Group Health appeals committee decision notice.

Requests can be mailed to the addresses listed under "Claims Denied for Reasons Other Than Eligibility."

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because Group Health indicates you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative may file a written appeal. You have 180 days after receiving a notice of your eligibility determination from the county or Group Health to submit a written appeal. It must include:

- your name and address, as well as each dependent's name and address, if applicable;
- your hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

A Benefits, Payroll and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 1-206-684-1556 to file an urgent appeal). These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary). These relate to claims for a benefit that must be approved before the patient receives medical care—for example, requests to precertify a hospital stay;
- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary). These appeals involve the payment or reimbursement of costs for medical care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits, Payroll and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits, Payroll and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your dependent is denied plan participation, or you forfeit your right to legal action.

Dental

If a properly filed claim is denied in whole or in part, Delta Dental of Washington notifies you and your provider with an explanation in writing. Delta Dental may deny a claim on the basis of eligibility or for other reasons.

Claims Denied for Reasons Other Than Eligibility

If you or your authorized representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling or writing Delta Dental and requesting an appeal of the decision. If you're dissatisfied with the outcome of the review, you may request a second review by the Delta Dental Appeals Committee.

You have 180 days after receiving a claim denial notice to request an appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Delta Dental will review your written appeal and notify you or your representative of its decision within these time frames:

- within 72 hours for urgent appeals. These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 30 days for post-service appeals. These appeals involve the payment or reimbursement of costs for dental care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

For second-level appeal reviews, your request for a review by the Delta Dental Appeals Committee must be made within 90 days of the postmarked date of the letter notifying you of the informal review decision. Your request should include the information noted above, plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Delta Dental Appeals Committee includes only persons who weren't involved in either the original claim decision or the informal review. The Delta Dental Appeal Committee will review your claim and make a determination within 30 days of receiving your request, or within 20 days for experimental/investigational procedure appeals, and send you a written notification of the review decision. Upon request, you'll be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, Delta Dental will consult with a dental professional advisor.

The decision of the Delta Dental Appeals Committee is final. If you disagree with the outcome of your appeal and you have exhausted the appeals process provided by your plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter. If legal action is taken, the suit must be filed within six years after the event on which the claim is based or you forfeit your right to legal action.

AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and whom Delta Dental can contact regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process won't commence until this form is received. If the form or some other document confirming the right of the individual to act on your behalf (that is, power of attorney) isn't returned, the appeal will be closed.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because Delta Dental indicates that you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- your name and address, as well as each dependent's name and address (if applicable);
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

A Benefits, Payroll and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 1-206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);
- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary);
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits, Payroll and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan, and its decision is final and binding. In reviewing your claim, Benefits, Payroll and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits, Payroll and Retirement Operations determines that you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits, Payroll and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits, Payroll and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your dependent is denied plan participation, or you forfeit your right to legal action.

Vision

If a properly filed claim is denied in whole or in part, VSP notifies you and your provider with an explanation in writing. VSP may deny a claim on the basis of eligibility or for other reasons.

Claims Denied for Reasons Other Than Eligibility

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling VSP and providing more information. If you'd rather communicate in writing or if the issue isn't resolved with a call, you may file a written appeal with VSP.

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

VSP will review the written appeal and notify you or your representative of its decision within this timeframe:

- within 30 days for post-service appeals (first- and second-level appeals). These appeals involve the payment or reimbursement of costs for vision care that has already been provided.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies plan provisions and his/her discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above. If the claim appeal is denied, you're notified in writing of reasons for the denial.

If you disagree with the resolution of your claim, you have 60 days after receiving the denial to submit a second-level appeal with any further documentation to VSP.

VSP has sole discretionary authority to determine benefit payment under the plans; its decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because VSP indicates that you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations at 1-206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- your name and address, as well as each dependent's name and address (if applicable);
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

A Benefits, Payroll and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 1-206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);
- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits, Payroll and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan, and its decision is final and binding. In reviewing your claim, Benefits, Payroll and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits, Payroll and Retirement Operations determines that you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits, Payroll and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits, Payroll and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your dependent is denied plan participation, or you forfeit your right to legal action.

Flexible Spending Accounts

If a properly filed claim is denied, you (or your representative) may submit a written appeal to:

WageWorks Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

Your written appeal must be filed within 180 days after you receive the initial notice of denial from WageWorks. You must indicate the reason for your appeal and may include any relevant information or documents.

WageWorks will give you a written decision within 60 days of receiving your appeal, indicating the specific plan provision behind the decision and advising you of your right to obtain free copies of related documentation.

If the appeal is denied, you may pursue legal remedies, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event on which the claim is based.

Long-Term Disability Insurance

The county administers eligibility for participation in the long-term disability (LTD) insurance plan according to the terms of the insurance contract. CIGNA Group Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

If your claim is denied, you'll be notified in writing of the reasons for the denial, your right to appeal and your right to obtain copies of all documents related to your claim that were reviewed by CIGNA in making the determination.

Claims Denied for Any Reason

If you disagree with the claim denial, you or your representative (referred to as "you" in the rest of this section) may attempt to resolve any misunderstanding by calling CIGNA and providing additional details. If you prefer to communicate in writing or are unable to resolve the issue with a phone call, you may file a written appeal. You have 180 days after receiving the claim denial notice to file a written appeal. Be sure to include the reasons for your appeal and any information or documentation helpful in reviewing your claim.

CIGNA will review your written appeal and notify you of its decision within 45 days after receiving your appeal. If CIGNA requires additional time, you'll be notified in writing that an additional period of up to 45 days is necessary.

CIGNA will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

CIGNA has sole discretionary authority to determine payment of LTD benefits, and its decision is final and binding. In reviewing your claim, CIGNA applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and CIGNA determines you're entitled to the benefits.

If your appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within three years after the time written proof of loss is required to be furnished or you forfeit your right to legal action. If you don't file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits, Payroll and Retirement Operations at 1-206-684-1556 or kc.benefits@kingcounty.gov. You may also write to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Life Insurance Plan

The county administers eligibility for participation in the life insurance plan according to the terms of the insurance contract. Aetna Life Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

If your claim is denied, you'll be notified in writing of the reasons for the denial, your right to appeal and your right to obtain copies of all documents related to your claim that were reviewed by Aetna in making the determination.

Claims Denied for Any Reason

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as "you" in the rest of this section) may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Aetna will review the written appeal and notify you of its decision within 60 days after receiving the appeal. If Aetna requires additional time, you will be notified in writing that an additional period of up to 60 days is necessary.

Aetna will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

Aetna has sole discretionary authority to determine benefit payment under the life insurance plan, and its decision is final and binding. In reviewing your claim, Aetna applies the plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Aetna determines that you're entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event on which the claim is based. If you don't file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits, Payroll and Retirement Operations at 1-206-684-1556 or kc.benefits@kingcounty.gov. You may also write to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Accidental Death and Dismemberment Insurance Plan

The county administers eligibility for participation in the accidental death and dismemberment (AD&D) insurance plan according to the terms of the insurance contract. CIGNA Group Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

If your claim is denied, you'll be notified in writing of the reasons for the denial, your right to appeal and your right to obtain copies of all documents related to your claim that were reviewed by CIGNA in making the determination.

Claims Denied for Any Reason

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as "you" in the rest of this section) may try to resolve any misunderstanding by calling CIGNA and providing more information. If you'd rather communicate in writing or if the issue isn't resolved with a call, you may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

CIGNA will review your written appeal and notify you of its decision within 60 days after receiving the appeal. If CIGNA requires additional time, you'll be notified in writing that an additional period of up to 60 days is necessary.

CIGNA will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

CIGNA has sole discretionary authority to determine benefit payment under the AD&D insurance plan, and its decision is final and binding. In reviewing your claim, CIGNA applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and CIGNA determines you're entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within three years after the time written proof of loss is required to be furnished. If you don't file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits, Payroll and Retirement Operations at 1-206-684-1556 or kc.benefits@kingcounty.gov. You may also write to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Assignment of Benefits

Plan benefits are available only to you and the eligible dependents you cover. In general, they cannot be assigned or given away to another person and are not subject to attachment or garnishment. However, there are exceptions. Contact Benefits, Payroll and Retirement Operations for details.

Determining Payment of Benefits

In paying for services, the plans may, at their option, pay you, the provider or another third-party administrator. The plans also will make payments on behalf of an enrolled child to his/her parent who may not be enrolled in the plan or to a state Medicaid agency when required to do so by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. When the plans make payments according to the information in this section, they're released from liability to anyone who disagrees with their decision to pay certain individuals or agencies.

Third-Party Claims

If you receive health benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. Third-party claims are handled differently by the different health plans. (For details, see the separate sections on third-party claims under KingCare℠, Group Health, Delta Dental and VSP in the *Health Care* section.)

Correcting Mistakes in Payments

Each plan has the right to recover amounts it paid that exceed the amount for which it is liable. These amounts may be recovered from one or more of the following (to be determined by the plan):

- persons to or for whom the payments were made;
- other insurers;
- service plans; and
- organizations or other plans.

These amounts may be deducted from your future benefits or a dependent's benefits, even if the original payment wasn't made on the dependent's behalf.

The plan's right of recovery includes benefits paid in error due to, but not limited to, any false or misleading statements made by you or your dependents.

Change or Termination of the Plans

The county fully intends to continue the plans indefinitely but reserves the absolute right to amend or terminate them, in whole or in part, for any reason at any time, according to the amendment and termination procedures described in the legal documents. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

Employment Rights Not Implied

The benefit information in this guide does not create a contract of employment between the county and any employee.

Contact Information

For questions about...	Contact...	By writing or calling...	Or visiting or e-mailing...
How to enroll in health coverage	Benefits, Payroll and Retirement Operations	The Chinook Building, CNK-ES-0240 401 Fifth Ave. Seattle, WA 98104-2333 1-206-684-1556 1-206-296-7700 (fax)	www.kingcounty.gov/employees/benefits kc.benefits@kingcounty.gov
How to find benefits information and forms	Benefits, Payroll and Retirement Operations	The Chinook Building, CNK-ES-0240 401 Fifth Ave. Seattle, WA 98104-2333 1-206-684-1556 1-206-296-7700 (fax)	www.kingcounty.gov/employees/benefits kc.benefits@kingcounty.gov
Healthy Incentives	Benefits, Payroll and Retirement Operations	The Chinook Building, CNK-ES-0240 401 Fifth Ave. Seattle, WA 98104-2333 1-206-684-1556 1-206-296-7700 (fax)	http://www.kingcounty.gov/audience/employees/healthy-incentives.aspx kc.benefits@kingcounty.gov
KingCare℠ Group No. 10017241	For medical: Regence	1-800-376-7926	www.regence.com (As a member, you can register and sign in to view your claims and benefits information and get access to members-only tools, such as emailing customer service)
	For claims reimbursement: Regence	Regence BlueShield P.O. Box 30271 Salt Lake City, UT 84130-0271	www.regence.com (As a member, you can register and sign in to view your claims and benefits information and get access to members-only tools, such as emailing customer service)
	For medical preauthorizations: Regence	1-800-376-7926	N/A
	For prescription drugs: Express Scripts	Express Scripts, Inc. Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872 Express Scripts Home Delivery Service P.O. Box 52112 Phoenix, AZ 85072-2122 1-800-332-2213 1-800-899-2114 (TTY)	www.express-scripts.com

For questions about...	Contact...	By writing or calling...	Or visiting or e-mailing...
Group Health Gold Group No. 0953800 Silver Group No. 0975800 Bronze Group No. 0975900	Group Health	Group Health P.O. Box 34585 Seattle, WA 98124-1585 1-888-901-4636	www.ghc.org info@ghc.org
		For mail-order prescriptions: 1-800-245-7979	For online prescription drug refills: www.MyGroupHealth.com
Dental plan Group No. 00152	Delta Dental of Washington	Delta Dental of Washington P.O. Box 75983 Seattle, WA 98175-0983 1-866-229-4102	www.deltadentalwa.com cservice@deltadentalwa.com
Vision plan Group No. 12-029826	Vision Service Plan (VSP)	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 1-800-428-4833 (TTY)	www.vsp.com
Flexible spending accounts	WageWorks	WageWorks P.O. Box 14055 Lexington, KY 40512 1-877-502-6272 1-877-220-3249 (fax)	www.wageworks.com
Long-term disability (LTD) insurance Group No. FLK-980001	CIGNA Group Insurance	CIGNA Group Insurance CIGNA Customer Service Center P.O. Box 20310 Lehigh Valley, PA 18002-0310 Glendale Disability Claims Office 400 North Brand Blvd, Suite 500 Glendale, CA 91203 For conversion: 1-800-557-7975, ext. 7424 For claims: 1-800-362-4462	https://dmswebintake.group.cigna.com

For questions about...	Contact...	By writing or calling...	Or visiting or e-mailing...
Life insurance Group No. 723832	Aetna Life Insurance	Aetna Life Insurance Company P.O. Box 14547 Lexington, KY 40512-4547 For conversion/ portability: 1-800-826-7448 For claims and evidence of insurability: 1-800-523-5065 For beneficiaries: 1-800-523-5065 to request paper copy For customer service: 1-888-584-2983 1-800-803-5934 (fax)	N/A
Accidental death and dismemberment (AD&D) insurance Group No. OK821586	CIGNA Group Insurance	CIGNA Group Insurance CIGNA Customer Service Center P.O. Box 20310 Lehigh Valley, PA 18002-0310 For conversion: 1-800-557-7975, ext. 7424 For claims: 1-800-362-4462 For beneficiaries: 1-800-557-7975, ext. 7767 For travel assistance in the U.S./Canada: 1-888-226-4567 Collect outside U.S./Canada: 1-202-331-7635 Fax for travel assistance: 1-202-331-1528	For travel assistance: Cigna@europassistance-usa.com
COBRA	WageWorks	WageWorks P.O. Box 14055 Lexington, KY 40512 1-877-502-6272 1-877-220-3249 (fax)	www.wageworks.com

For questions about…	Contact…	By writing or calling…	Or visiting or e-mailing…
King County Employees Deferred Compensation Plan	Benefits, Payroll and Retirement Operations	Benefits, Payroll and Retirement Operations The Chinook Building, CNK-ES-0240 401 Fifth Ave. Seattle, WA 98104-2333 T. Rowe Price P.O. Box 17215 Baltimore, MD 21297-1215 For county assistance: 1-206-263-9250 For T. Rowe Price assistance: 1-888-457-5770	If you're enrolled: http://rps.troweprice.com If you're not enrolled: http://rps.troweprice.com/scm/scmKingCounty/0,,,00.html
State retirement information	Washington State Department of Retirement Systems	Washington State Department of Retirement Systems P.O. Box 48380 Olympia, WA 98504-8380 1-800-547-6657	www.drs.wa.gov recep@drs.wa.gov
City of Seattle retirement information	Seattle City Employees' Retirement System	Seattle City Employees' Retirement System 720 Third Avenue, Suite 1000 Seattle, WA 98104-1829 1-206-386-1293 1-206-386-1506 (fax)	www.seattle.gov/retirement
Making Life Easier	Making Life Easier	1-888-874-7290	www.kingcounty.gov/employees/EAP
Individual insurance policies	Statewide Health Insurance Benefits Advisors (SHIBA)	SHIBA HelpLine Office of Insurance Commissioner P.O. Box 40256 Olympia, WA 98504-0256 1-800-562-6900 1-206-727-6221 (King County only)	www.insurance.wa.gov/shiba SHIBAhelpLine@oic.wa.gov
Medicare	Centers for Medicare & Medicaid Services, Region 10	Centers for Medicare & Medicaid Services, Region 10 2201 Sixth Avenue, MS-40 Seattle, WA 98121 1-206-615-2306 1-206-615-2027 (fax)	www.medicare.gov

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